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Including Syphilis

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GEORGE M. MACKEE, M.D. FRED WISE, M.D.

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INCLUDING SYPHILIS

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXXVI—No. 9 SEPTEMBER, 1918 WHOLE No. 430

Original Communications

CONCERNING BRUCK'S NITRIC ACID REACTION WITH SERUM AND CEREBROSPINAL FLUID IN SYPHILIS *

IKUZO TOYAMA, M.D., AND JOHN A KOLMER, M.D.
PHILADELPHIA

Recently Bruck[1] has described a simple chemical reaction in syphilis which he believes may be due to the same changes in the serum as are responsible for the phenomenon of complement fixation, and may prove of value in conjunction with the Wassermann reaction as a specific aid in the diagnosis of syphilis. The technic of the test is extremely simple and based on the experimental observation that the precipitate formed from the serum of a syphilitic on the addition of nitric acid, does not dissolve in distilled water as readily or as completely as the precipitate formed with normal or nonsyphilitic serums.

With about 200 syphilitic serums, Bruck found that his test yielded the same results as observed with the Wassermann reaction. Only three Wassermann positive serums, from one latent and two secondary cases, gave negative nitric acid reactions. On the other hand, one case of congenital syphilis and one tertiary case gave positive nitric acid reactions, although the Wassermann test was negative. Of about 200 nonsyphilitic patients, all were negative except four cases of old infected wounds of knee and thigh, and one case of tuberculosis. As all of the latter patients were febrile, a positive reaction with the serum of a febrile patient is regarded as unreliable. As far as we are aware, neither Bruck nor others who have employed his test have recorded experiments with cerebrospinal fluid; we have included in our study fluids from syphilitic patients and particularly from well developed cases of paresis, also from persons suffering with meningococcic meningitis, with negative results in all, due to the complete

* From the Dermatological Research Laboratories of the Philadelphia Polyclinic, Dr. Jay F. Schamberg, Director.

1. Bruck, C.: Eine Sero-Chemische Reaktion bei Syphilis, München. med. Wchnschr., 1917, 64, p. 25.

solution of the precipitate formed when the nitric acid reagent was added to not only 0.5 c.c. of fluid but multiples thereof up to 2 c.c.

Smith and Solomon[2] have reported their results with the serums of 405 cases and insist on several refinements of technic not emphasized by Bruck. In 101 of their cases there were definite clinical manifestations of syphilis in which the Wassermann and Bruck tests agreed positively in seventy-four, or 75 per cent. The two tests agreed negatively in twelve instances and were at variance in fifteen. In the group which showed syphilis of the nervous system there were sixty-four cases of clinically certain general paresis, of which the Wassermann and Bruck tests agreed in fifty-four instances, or practically 85 per cent. In other forms of central nervous system involvement the agreement was 100 per cent. in fifteen cases tested. In the cases with no apparent involvement of the nervous system the agreement was somewhat less, being 76 per cent. This was considered to be in keeping with the fact that the Wassermann test was not so strongly positive in these cases. The authors considered the advantages of the test to be: (1) the short time required to perform the test; (2) the limited amount of apparatus necessary, and (3) the simplicity of the technic. The disadvantages of the test seemed for the most part, to be bound up in the personal variations that were apt to occur. Stillians[3] applied the test with the serums of 209 cases. In fifty-three of these, more than 25 per cent., the results disagreed with those of the Wassermann reaction. In thirteen cases of active early syphilis, in all of which the Wassermann reaction was very strongly positive, the new test was negative; on the other hand, 24 per cent. of seven of seventy-four nonsyphilitic patients gave positive Bruck reactions, and the author regards the test as useless for diagnostic purposes.

EXPERIMENTAL

Technic.—We have applied Bruck's test with the serums of 100 persons, the majority of whom were under treatment in the syphilis clinic of Dr. Jay F. Schamberg, with the following technic as described by Bruck:

(a) Clear corpuscle-free serums were employed. Opalescent serums as those obtained by bleeding shortly after a meal, also serums deeply tinged with hemoglobin or contaminated with bacteria are regarded as unsatisfactory and were not employed. Practically all serums were used in a fresh active condition and also after heating or inactivation at 56 C. for thirty minutes.

2. Smith, C. E., and Solomon, H. C.: The Bruck Sero-Chemical Test for Syphilis, Boston Med. and Surg. Jour., 1917, 177, pp. 321-324.

3. Stillians, A. W.: The Bruck Precipitation Test for Syphilis, Jour. Am. Med. Assn., 1917, 69, pp. 2014-2016.

(b) In conducting the test 0.5 c.c. serum was placed in a large perfectly cleansed test tube and 2 c.c. of sterile distilled water added, followed by gentle mixing to avoid frothing. The exact time being noted with a watch, 0.3 c.c. of a 25 per cent. dilution of C. P. nitric acid with a specific gravity of 1.149 was added,* the mixture gently shaken and stood aside at room temperature (about 15-18 C.) for exactly ten minutes. While the acid was being added, the tube was gently shaken, to prevent the formation of a precipitate with normal serum which dissolves with difficulty. Bruck has emphasized the necessity of accuracy in measurement of serum and reagent and strict observance of the time limits; if more than ten minutes are allowed for precipitate formation, a larger time is required for its solution in the following step, resulting in confusion in the interpretation of results. For this reason the serologist should not attempt to conduct more than twelve tests at one time.

(c) To the white precipitate was now added exactly 16 c.c. of distilled water, the test tube capped with a finger and carefully inverted three times without the production of a froth. After standing ten minutes the tube was again capped and carefully inverted three times.

(d) After standing at room temperature for half an hour, the reactions were read. With normal serum the precipitate is supposed to dissolve completely, the water being clear or slightly opalescent; with syphilitic serums small flakes are supposed to be present which show little or no tendency to dissolve. Bruck suggested that readings are facilitated if the tubes are allowed to stand from several to twelve hours when the precipitates may gravitate to the bottom of the test tubes; we made preliminary readings and allowed the tubes to stand over night when the final readings were made. Tubes showing a well defined sediment were read as positive; those showing only a slight sediment ("kleine Kuppe") as doubtful, and tubes with no sediment and clear or slightly opalescent water as negative. With well defined positive or negative reactions, we experienced no difficulty in reading the results of the tests, but not infrequently the doubtful reactions were puzzling and read differently by different persons.

(e) With the cerebrospinal fluids the same technic was employed except that in addition to using 0.5 c.c. as in the serum test, we have used larger amounts up to and including 2 c.c. of fluid. The amount of precipitate produced with the largest amount of spinal fluid containing large amounts of protein as from persons suffering with menin-

* The nitric acid of the U. S. pharmacopeia contains 68 (British pharmacopeia 70) per cent. by weight of concentrated acid and a specific gravity of 1.403. A 25 per cent. dilution with a specific gravity of 1.149 is prepared by diluting 100 c.c. of the acid with 225 c.c. of distilled water.

gococcic and pneumococcic meningitis, was invariably dissolved within a few minutes after the addition of distilled water, rendering the water clear or but slightly opalescent and thereby yielding negative reactions.

(f) All serums and spinal fluids were tested for the Wassermann reaction with three different antigens, namely, an alcoholic extract of beef heart reenforced with cholesterin, an alcoholic extract of syphilitic liver, and an extract of acetone insoluble lipoids of beef heart.

RESULTS

(a) *Comparison of Results with the Wassermann and Bruck Tests.* —The results with 94 serums in both tests were as follows: the Bruck tests were conducted with fresh unheated serums and the results read after standing overnight:

1. With fifty-eight serums, or about 62 per cent., the Wassermann and Bruck tests were positive; these figures include the weakly and strongly positive reactions with both tests. All of these reactions occurred with the serums of frankly syphilitic persons, the majority manifesting the lesions of the late secondary or tertiary stages of the disease and undergoing treatment with arsphenamin (arsenobenzol*).

2. With seven serums, or about 8 per cent., the reactions were negative with both tests and the patients presented no clinical evidences of syphilis. *Both tests agreed therefore with 65 serums, or about 70 per cent.*

3. With twenty-three serums, or about 25 per cent., the Wassermann reactions were negative with all antigens and the Bruck tests positive (strongly positive in sixteen and weakly positive in seven); these results call for further analysis.

With eight serums the patients exhibited no clinical evidences of syphilis and the histories were negative (although we have learned to place little reliance on a negative history), and, presumably, the Bruck test yielded a falsely positive result.

With fifteen serums the patients were frankly syphilitic and undergoing vigorous treatment with arsphenamin (arsenobenzol); eight of these persons presented the lesions of secondary syphilis at the time of entering Dr. Schamberg's clinic and the balance may be classified as being in the tertiary stage of the disease. All of these persons had received from two to nineteen intravenous injections of arsphenamin (arsenobenzol), and all had exhibited positive Wassermann reactions on entering the clinic and at a date prior to the time when the Bruck tests were conducted. It would appear therefore that the

* Prepared in the Dermatological Research Laboratories of the Philadelphia Polyclinic by Drs. Jay F. Schamberg, George W. Raiziss and John A. Kolmer.

property of syphilitic serum responsible for the Bruck reaction disappears more slowly under treatment than the antibody or reagin involved in the Wassermann reaction.

4. With the serums of six persons, or about 6 per cent., the Wassermann tests were positive and the Bruck tests read as negative. Four of the patients were in the secondary stage of syphilis and had received from three to eight injections of arsphenamin; the remaining two were in the tertiary stages and had received two and three injections of arsphenamin, respectively.

(b) *Comparison of Results of Bruck Tests with Fresh Unheated and Heated Serums.*—Bruck states that a serum yields the same results in his test whether heated or unheated; Stillians tried 115 serums before and after heating and observed the same result in ninety-eight. Of the seventeen serums yielding different results, fourteen gave a positive reaction in the active state and negative after inactivation, while the reverse occurred with three serums. That these differences were not all accidental, is indicated according to Stillians, by the fact that a repetition of these tests in many instances gave exactly the same result.

We have tested the serums of eighty-nine persons in the fresh unheated state and at the same time immediately after heating in a water bath at 56 C. for one-half hour with the following results:

1. With seventy-six serums, or about 85 per cent., the results were similar.

2. With twelve serums, or about 13 per cent., the Bruck tests were positive with fresh unheated serum and negative after heating; these results are quite similar to those reported by Stillians. Three of these serums were from cases of secondary syphilis after receiving from one to eleven injections of arsphenamin and showing positive Wassermann reactions in two and negative in one, while the remaining nine cases were classified as presenting tertiary lesions and had received from six to twenty injections of arsphenamin, with positive Wassermann reactions with four and negative reactions with five of the serums. The reverse was found with the serum of one person in the tertiary stage of the disease presenting a positive Wassermann reaction and receiving no treatment at the time the tests were conducted; opportunity was not afforded for repeating the tests with the serum of this person.

It would appear, therefore, that fresh unheated serum is better adapted for the Bruck test than heated serum.

(c) *Comparison of Results of Bruck Tests Read Immediately and After Standing at least Twelve Hours.*—As previously stated, Bruck claims that the reading of the results of his test is facilitated by per-

mitting the tubes to stand at room temperature for at least twelve hours before reading the results; our experience is in accord with his in that the readings are easier and more regular after the tubes had stood for sufficient time to permit the precipitate to collect on the bottom of the test tube.

The results of tests with ninety-two fresh and unheated serums read at the end of one-half hour after setting up and again after standing over night, have shown the following:

1. With eighty-seven serums, or about 94 per cent., the results were similar insofar as + or — were concerned; in several instances a reaction was recorded as ± in the preliminary reading and + the following day or vice versa.

2. With five serums, or about 6 per cent., the preliminary reading was + and the final reading next day as —; all serums were from secondary cases of syphilis yielding positive Wassermann reactions with four, and after receiving from two to ten doses of arsphenamin.

SUMMARY

1. Wassermann and Bruck tests with ninety-four serums (the Bruck tests being conducted with fresh active serums) yielded similar results with sixty-five serums, or about 70 per cent. All of the positive reactions with both tests occurred with the serums of persons manifesting the lesions of the secondary and tertiary stages of syphilis and undergoing treatment with arsphenamin (arsenobenzol of the Dermatological Research Laboratories).

2. With the serums of twenty-three persons, or about 25 per cent., the Wassermann tests were negative and the Bruck tests positive; eight of these serums were from persons regarded as nonsyphilitic and the balance (fifteen) from persons in the secondary and tertiary stages of sypilis undergoing vigorous treatment with arsphenamin and yielding positive Wassermann reactions on admission to the clinic and prior to the time when Bruck tests were made. According to these results, therefore, the Bruck test was found to yield presumably about 8 per cent. falsely positive reactions; also that the property of syphilitic serum responsible for the Bruck test probably persists under treatment for a longer period than the reagin or Wassermann antibody.

3. With the serum of six persons, or about 6 per cent., the Wassermann tests were positive and the Bruck tests regarded as negative; all of these serums were from persons presenting the lesions of the secondary and tertiary stages of syphilis on entering the clinic and undergoing active treatment with arsphenamin.

4. The results of Bruck tests conducted with eighty-nine serums in the fresh active state and again after inactivation (heating) showed

similar results in 85 per cent.; in 13 per cent. the reactions were positive with active and negative with inactive serum; all serums were from cases of secondary and tertiary syphilis undergoing treatment. It would appear, therefore, that active serum is better adapted for the Bruck test than inactivated serum.

5. Preliminary and final readings of the Bruck test agreed in 94 per cent. of serums; with 6 per cent. of serums the reaction was read as positive in the preliminary and negative in the final reading. These serums were from persons in the secondary stage of syphilis and undergoing vigorous treatment; it would appear, therefore, that the precipitate yielding a positive result in the preliminary reading may dissolve over night and thereby render a negative result in the final reading. For this reason the preliminary reading is considered more delicate but more difficult to interpret and differentiate from the opalescent reactions sometimes yielded by normal serum.

6. Bruck tests conducted with cerebrospinal fluids in amounts ranging from 0.5 to 2 c.c. were invariably negative irrespective of the source of fluid as from normal persons or those suffering with syphilis of the central nervous system and suppurative meningitis; owing to the relatively small amount of precipitable substance in spinal fluid even in the largest amount employed, and from inflamed meninges, as compared with serum, the Bruck test is worthless as an aid in diagnosis.

7. While the Bruck serochemical test is very simple, of great interest theoretically and probably of more value than the numerous other physicochemical tests of Porges and Meier, Klausner, Herman and Perutz and others, the reactions are less well defined and more difficult to read and more prone to error on the personal equation than the Wassermann reaction and, likewise, probably less delicate and valuable as a diagnostic reaction than the Wassermann test when the latter is properly conducted by experienced persons.

CHEMICAL CHANGES IN THE SUBCUTANEOUS FAT IN SCLEREMA NEONATORUM *

CLAYTON S. SMITH, PH.D.
CHICAGO

Because of the relative infrequency of sclerema neonatorum, there have been few opportunities afforded for its study. Of the cases reported, only a few contain chemical data. This, no doubt, is explained by the fact that each case yields only a small amount of material for analysis. Further, several determinations of each analytic constant must be made in order to insure a reasonable degree of accuracy. It becomes evident, then, that each case of the disease can at best furnish only a small contribution to the total sum of information needed to explain what takes place.

REVIEW OF LITERATURE

One of the earliest studies of subcutaneous fat in normal and scleremic infants was made by Langer[1] in 1881. He found normal infant fat to be a fairly solid mass, melting at 45 C., while that of adults at room temperature was almost entirely fluid, solidifying only at 0 C. The infant fat contained about 31 per cent. of the solid fatty acids, principally stearic and palmitic, but that of the adults contained only 10 per cent. of these acids. He noted that the body temperature of the infants was from 37.73 to 37.80 C., or slightly higher than the normal adult temperature. Langer believed that the scleremic condition in infants was due to the fact that the body temperature was not sufficient to keep the fats in solution. He suggested that the lowering of the body temperature might be due to improper clothing or exposure to cold air or water.

In 1897, Knopfelmacher[2] made a very careful study of the chemical constituents of infant fat. He laid particular stress on the iodin absorption of fat, and tabulated this value, together with the melting and solidifying points for infant fat from birth until one year. As a result of his experiments, he concluded that the fat in the panniculus adiposus at the end of the first year has the same oleic acid content as that of an adult, and that, from this time on, it remains fairly constant. Because of this gradual increase in oleic acid, he claimed that sclerema was seldom possible after the second, and never possible after the

* From the Laboratory of Physiological Chemistry, College of Medicine, University of Illinois.

1. Langer: Wien. med. Presse, 1881, 22, p. 1375.
2. Knopfelmacher: Jahrb. f. Kinderh., 1897, 45, p. 177.

sixth month. Knopfelmacher believed sclerema to be due to a loss of fluidity of the body fat and to the lowering of the body temperature. Young infants were believed to be particularly susceptible because of the higher melting point of their fats.

In his investigation of the fat of infants and of the fat content of the liver in gastro-enteritis, Thiemich[3] found, as did Knopfelmacher, that the fat of a newly born, well nourished infant was richer in oleic acid than that of a poorly nourished infant. He was unable to find any parallelism between the general constitution and the oleic acid content of the subcutaneous fat.

In 1905, Miura[4] was able to obtain material enough for a chemical study of the subcutaneous fat of an infant dying of sclerema neonatorum. At the same time, he made a study of the tissue of a mature new-born child. He found 41.31 per cent. oleic acid in the fat of the normal child and 40.32 per cent. in the fat of the scleremic child. Miura concluded that the fat of scleremic infants did not differ materially from the fat of normal infants of the same age. He believed, however, that the subcutaneous tissue of the newly born was structurally predisposed to undergo hardening at a lower temperature than that of an older child, but that the actual cause of this hardening had yet to be found.

Sarvonat[5] in 1906 reported a case of sclerema neonatorum in which the body temperature was at no time below normal, and on several occasions was much above the normal temperature. Together with his clinical report, he published the result of an analysis of the subcutaneous fat, which briefly was as follows:

Melting point 23 C.
Iodin Number (Hubl) 43

Oleic acid constituted 56 per cent. of the fatty acids obtained. These properties are not strikingly different from the fat of normal infants of the same age. Sarvonat concluded that neither the body temperature nor the oleic acid content would explain the hardening of the tissues.

Bayer[6] reported two cases of twins in which one twin in each set was scleremic. One of the normal infants died from asphyxia and the fat obtained from it was used in control experiments. Briefly, Bayer's findings for scleremic infants were as follows:

Determination of the solidifying points yielded inconsistent results. The melting points showed a pronounced increase above the normal, being in one case 52 C. and in the other 70. The oleic acid content in these two cases was

3. Thiemich: Ztschr. f. physiol. Chem., 1898, 26, p. 189.
4. Miura: Japan. Ztschr. f. Dermat. u. Urol., 1905, 5, p. 412.
5. Sarvonat: Arch. de med. des enfants, 1906, 9, p. 22.
6. Bayer: Verhandl. d. deutsch. path. Gesellsch., 1908, 12, p. 305.

between 23 and 24 per cent. The control determinations showed a solidifying point of 17 C., melting point 35, oleic acid content 62 per cent., equals iodin number 47 (Hubl).

In another case of scleremic twins in which both came to necropsy, Bayer found the oleic acid content to be from 35 to 38 per cent. As a result of his determination, he concluded that sclerema neonatorum was due to a lack of oleic acid, but was unable to say what brought about this change.

Aside from these analyses of infant fats in cases of sclerema neonatorum, there have been results of normal fat analyses reported. A study was made of the analytic constants of human fat by Mitchell.[7] He concluded that human fat consisted of 70 per cent. liquid acids, principally oleic, and 30 per cent. solid acid, probably palmitic with small amounts of stearic and myristic. It might be added that his separation of the fatty acids was probably faulty, because of imperfect methods.

A similar study of human fat was made by Jaeckle[8] in 1902. He found adult human fat to consist essentially of simple glycerids of oleic, palmitic and stearic acids. He could not detect traces of other lower fatty acids. The composition of human fat was found to be subject to wide variation. He noted also that there was a marked difference between the fat of infants and that of adults, in that the former was richer in solid fatty acids and poorer in oleic acids than the latter.

AUTHOR'S CASE

The case which affords the material for this paper was that of a child who contracted sclerema on the fifteenth day and who succumbed five days later. The necropsy revealed no pathologic condition other than that of the subcutaneous tissue. The most marked scleremic area was about the right cheek. As much as possible of the normal and abnormal tissue was dissected out and dried in a desiccator over calcium chlorid. This dried material was then extracted with ether in a glass-stoppered bottle at room temperature. From time to time, the ether was changed and finally the total ethereal extract in each case was allowed to evaporate spontaneously. The residue was then dried in a desiccator over calcium chlorid. Because of the small amount of material (15 gm.) available, only a few determinations could be made. The following were selected: melting point (Wiley method), iodin number (Hubl), saponification, and acid numbers.

The normal fat yielded fairly consistent results in the determination of the melting point. The abnormal fat did not show a sharp

7. Mitchell: Analyst, 1896, 21, p. 171.
8. Jaeckle: Ztschr. f. physiol. Chem., 1902, 36, p. 53.

melting point, but seemed to consist of two fats, one melting around 33 C. and the other at about 38 C. This may be due to the fact that in the abnormal area not all of the fat was completely changed. A series of five determinations on both the normal and abnormal fats failed to reveal any appreciable difference in the iodin numbers. The fats could not be differentiated by their saponification numbers because there was not sufficient difference in the values obtained. There was, however, a marked difference in the acid numbers of the two fats, that of the abnormal being much higher. Duplicate determinations were made only in the case of these last two constants, as material was not available for a more extended study.

The results obtained are summarized in the accompanying table, together with similar data from the literature.

RESULTS OF CHEMICAL CHANGES IN TISSUE IN SCLEREMA

Scleremic Infant

	Melt. Point	Iodin No.	Sap. No.	Acid No.
Normal	33.96	44-46	193	79
Abnormal	37.5	44-48	190	163

Human Fat Constants

Age	Melt. Point	Iodin No.	Sap. No.	Acid. No.	Observer
New born	43	38.7	...	.....	Knopfelmacher
Infant*	23	43	...	.....	Sarvonat
Adult	17.5	62	195	6.3	Mitchell
New born	..	43.4	...	.....	Thiemich
New born	..	47.3	204	.72	Jaeckle
Adult	..	62-69	193-199	.39-1.036	Jaeckle

*Sclerema.

COMMENT

Inspection of the table shows that the iodin value found for the abnormal fat is practically the same as that found for the normal fat, and approximates closely the values reported by other investigators. From this, it may be safely assumed that the pathologic condition is not due to the absence of oleic acid. The acid values found for both the normal and the abnormal fat are higher than those recorded by other authors. The reason for this is not clear, but it may be due to individual variation. As the two samples were kept under the same conditions, however, and treated exactly alike, it is the relative difference between them that is the important factor. The results obained show that the abnormal fat had undergone a marked hydrolysis.

A somewhat similar case in which the subcutaneous fat underwent hydrolysis was reported by Fabyan.[9] His was a case of a well nourished colored infant, in whom there occurred multiple areas of fat necrosis in the subcutaneous tissue without any apparent involvement of the pancreas. The case Fabyan reported as fat necrosis differed in symptoms from sclerema neonatorum only in that the involved areas were more disseminated.

9. Fabyan: Bull. Johns Hopkins Hosp., 1907, 18, p. 349.

SUMMARY

The subcutaneous fat taken from an involved area in an infant who succumbed to sclerema neonatorum was found to be higher in fatty acid content than that of the normal tissue of the same child. There was no indication of any difference in the oleic acid content of the two fats. These findings would hardly justify a conclusion as to the cause of sclerema neonatorum, although they seem clearly to indicate that the change taking place is similar to fat necrosis and is not due to the absence of oleic acid.

The writer acknowledges his indebtedness to Prof. F. G. Harris for the material with which to carry on this investigation and for the clinical data contained therein.

THE TREATMENT OF SYPHILIS AT CAMP TRAVIS*

WILLIAM H. GUY, M.D.
Captain, M. R. C., U. S. Army
PITTSBURGH

With lay and professional magazines regaling their readers with stories of inefficiency, suggestions, criticisms and much misinformation —each author having the only solution for problems that confront the nation—it seems appropriate to say something about what is actually being accomplished and how it is being done. Each branch of the service has troubles peculiar to itself, the medical being no exception to the rule. The size of the task before us is not appreciated by any one not engaged in the work. Men are taken from every conceivable environment and walk of life and thrown together for the purpose of intensive military training, so that it is not surprising that every surgical and medical specialty finds its ability taxed to handle its quota. It is the purpose of this paper to give some idea of the work accomplished at Camp Travis, Texas, in the treatment of syphilis.

PROPHYLAXIS

Antisyphilitic treatment very appropriately begins with prevention of infection, every agency that tends to lessen the frequency of venereal disease being included. Just how much credit to place to any one factor is difficult to estimate—suffice it to say that the results obtained are most gratifying. Ninety-nine and the greater portion of the remaining 1 per cent. of syphilis was brought into the army by the draft. The few cases contracted since entering the service interest us most because they are preventable. Cleaning up the district has undoubtedly prevented many a venereal infection, as have also the activities of the vice squad. Alcohol has ceased to be a factor in the predisposition to venereal infections. Clean sports and entertainment for hours off duty have helped. Much has been accomplished by personal talks to the men explaining the dangers of venereal diseases. For the benefit of the man who disregards repeated warnings, certain measures are instituted; he is required to report as soon as possible to a prophylaxis station where, after thorough cleansing, one of the silver salts in solution of suitable strength is injected and held in the urethra for at least five minutes, after which 30 per cent. calomel ointment is applied externally with vigorous massage. We are informed that this is an effective prophylactic in 90 per cent. of cases. Records

* Permission to publish this report has been obtained from the Surgeon-General.

are kept of the date and hour of exposure and the date and hour of the prophylaxis in each case. Frequent venereal inspections are held, and men found with infections who have not taken prophylaxis are tried and punished by court martial. To date about 10,000 prophylactic treatments have been administered, and a fairly accurate check made on the results.

TYPES OF CASES TREATED

There have been 105 cases of venereal disease at this camp acquired since entering the service; of these, fifty-seven did not have prophylaxis. This record covers a period of about seven months. Contracted prior to enlistment we have seen about 3,000 cases, but the number of venereal patients is necessarily much larger, the reported cases representing only those with active manifestations. There certainly are a great many cases of chronic infection that we have not seen, and it seems logical to believe that some of the reported new venereal infections are but exacerbations of old conditions. The venereal wards are crowded with infections that existed prior to entering the service. Of syphilis, I rarely see a case acquired since entering the army.

EARLY DIAGNOSIS

By virtue of an early diagnosis and the prompt institution of vigorous specific treatment many a case of syphilis has undoubtedly been cured before the infection became generalized. To accomplish this, considerable cooperation between the various regimental infirmaries and the department of syphilology was necessary. Regimental surgeons were asked to refer every venereal ulcer for a dark field examination before any treatment was applied, every one being cautioned against the local application of antiseptics of all kinds until after the diagnosis had been established. All dark field examinations are made in my department; this enables me to see every case clinically and indicate the course to be pursued in each instance. Two negative dark field examinations are required before any venereal sore is released for treatment as nonsyphilitic. A record is kept of all dark field examinations with notation of the time for the patient to return for additional examination. The patient is instructed to use constant dressings of physiologic sodium chlorid solution locally until released for treatment. Regimental surgeons are asked to watch for the development of induration in lesions under treatment, and when seen to again refer the patient for examination. As many as six or eight examinations have been necessary before the spirochete was found in a few cases.

DIFFERENTIAL DIAGNOSIS

A nice question of judgment arises when repeated examinations are negative in indurated lesions. One must then rely on the history, the clinical appearance of the sore and on repeated Wassermann tests. Of cases in the new draft, several primary lesions were found, but the greater proportion had active secondary manifestations, so that but little trouble in diagnosis was experienced. But few tertiary or congenital cases have been seen.

LABORATORY DIAGNOSIS

A Wassermann test is made on each patient before any treatment is given, and is repeated before each course of treatment. Our laboratory uses the antisheep system, the antigen being a cholesterinized beef heart extract. Blood is withdrawn Mondays and Thursdays, the test proper being done Tuesdays and Fridays. To date about 1,500 reactions have been made, with positive results in about 20 per cent. of cases. The large proportion of negative results may be accounted for by the fact that a routine Wassermann test was required on certain groups of men. To my knowledge there have been no false positives. The test as performed has proved very delicate and thus an invaluable aid not only in diagnosis, but as a check on treatment as well.

RECORDS OF CASES

A syphilitic register is made out for each patient. This is a folder with space for name, rank, organization, date of birth and of enlistment, race, history, dark field and serologic results, treatment and notes on the progress of the case. If a soldier is transferred, his register goes with him, so that treatment may be followed until a cure is accomplished. Every patient is referred to the dentist before treatment is started. A thorough physical examination is made in each case before treatment is instituted, particular attention being paid the cardiovascular system and kidneys.

TREATMENT

Routine treatment comprises comparatively intensive courses of arsphenamin (salvarsan) or its equivalent with mercury, the two drugs being used in conjunction. An arsphenamin (salvarsan) injection and mercurial treatment are given each week for ten weeks, after which the patient is given a complete therapeutic rest for five weeks. Then his physical examination and the Wassermann test are repeated; another course of treatment is then started, and so on until the Wassermann reaction becomes and stays negative. We do not feel that any of our established secondary cases are cured as yet—sufficient time has

not elapsed—but I do feel that most of the primary types of the disease have been cured. The arsenobenzol brand of arsphenamin has been the arsenical preparation most used. The gravity method of administration is used, dosage being determined at the rate of 0.1 gm. for each 30 pounds of body weight. The usual preparation is ordered the night before, and in the case of ambulatory patients, light duty is advised for the afternoon following treatment. Patients with infectious lesions are treated in the hospital. The use of tobacco is forbidden. A mouth wash of potassium chlorate and phenol is used daily. Regular use of a tooth brush is insisted on. Silver nitrate is applied locally every other day to mouth lesions. Calomel ointment is applied with massage to chancres once daily, after which powdered calomel is dusted over the sore. In mixed infections local treatment is the same as that of the chancroid once the diagnosis of syphilis is made and systematic antisyphilitic treatment begun. When patients become noninfectious, they are returned to duty, the syphilitic register being forwarded by motorcycle messenger, who takes a receipt for it from the regimental surgeon. These receipts are kept on file, so that we may be able to trace lost registers. When on duty treatment is continued, mercury being given at the regimental infirmary, and the arsenobenzol brand of arsphenamin weekly at the base hospital. A cross index of all cases under treatment is kept for reference and as a check on the time patients are to return. The various organizations send their patients to the hospital at 9 a. m. on certain fixed days weekly for the arsenobenzol treatment. In this way we are better able to handle the large number of cases. Following injection, the men wait at least one-half hour, after which they are returned to their commands. The salicylate of mercury is given intramuscularly as a part of the routine treatment while in the hospital and after being returned to duty.

TECHNIC

A standard technic has been adopted and is used by all regimental surgeons, injections being given in the evenings so that the men do not lose any time. We begin with one-half to three-quarters grain and increase at the rate of one-quarter grain weekly if well tolerated until 2 or 2½ grains are given at each dose. As has been noted by others, we find that the amount of mercury which a patient will tolerate bears no relation to his body weight. In cases in which the diagnosis is made by the dark field method, treatment is more intensive than in the later stages of the disease, because we may then reasonably expect a prompt cure, provided the individual is physically able to stand intensive treatment. It is by no means a settled question as to how intensive this treatment should be, but every one agrees that it should be as intensive as possible with safety. There are those of us who believe with

Major Pollitzer that every syphilitic should receive an arsphenamin (salvarsan) injection on each of three or four successive days, followed by a course of mercury to toleration as routine treatment in patients physically fit. A few selected cases with primary lesions have been treated in this manner at Camp Travis with good results.

RESULTS

Though too early to draw conclusions, a positive Wassermann reaction has never been obtained in any of these cases. Our routine treatment in primary cases comprises 0.1 gm. of arsphenamin (salvarsan) for each 30 pounds of body weight, repeated twice the first week, followed by the usual weekly arsphenamin (salvarsan) and mercury for ten weeks; then the therapeutic rest for five weeks, after which a Wassermann test is made and the course repeated; then the case is kept under observation, Wassermann tests being made at intervals. In tertiary and certain late secondary cases routine courses are given plus the iodid of potassium to saturation.

To date about 400 cases of syphilis have been handled, some of them only for a short time because of transfer from place to place, others having just recently come under observation, and the number of cases under treatment is of course increasing. At present about 350 injections of the arsenobenzol brand of arsphenamin and the same number of treatments with mercury are given weekly.

CASTOR OIL

DOUGLASS W. MONTGOMERY, M.D.
SAN FRANCISCO

Castor oil is obtained from a beautiful plant with large palmate leaves, often called palma Christi, the palm of Christ. If, as a child, I had known this sonorous name it might have mitigated the misery I often suffered in having to take the oil. A very determined and energetic Scotch auntie regarded "a crumb o' oil," as she used to call it, as a universal remedy of exceeding potency in both moral and physical contingencies; and indeed, there is no doubt of its efficiency as a cleanser. Why it should be so cleansing to the bowels will be referred to later. Also, that chronic dyspeptic and ill natured critic, Thomas Carlyle, used to call castor oil "that oil of sorrow," and certainly it is a cause of double grief, both in the taking and in the administration, for there is no more painful experience either for the conscientious physician or the well meaning lay person, intent on giving a beneficent drug, than to have the patient obstinately refuse the succor extended. The irritating effect of this recalcitrancy is heightened when the patient is a constipated boy with a catarrhal and blubbering nose.

ITS VALUE IN DERMATOLOGY

In diseases of the skin the administration of castor oil is of importance inasmuch as a clean alimentary canal conduces to a clean cutaneous surface. It would appear that the medicine acts particularly on the ascending colon, and this is interesting as it is undoubtedly a fact that many of the more active skin reactions are caused by poisons generated in the caput coli, a favorite location for the anaerobic proteolytic bacteria.

W. B. Cannon noticed a serial sectioning of the contents of the ascending colon in an animal given castor oil with its food. This sectioning was done in such a manner as to resemble the sectioning of the contents of the small intestine. Each time the food was sectioned, however, it was swept back by antiperistalsis.[1] Such an action would be particularly well fitted to clear out the haustra of the colon, those pockets which in colonic sluggishness must tend to become especially dirty.

1. Cannon, W. B.: The Mechanical Factors of Digestion, Longmans, Greene & Co., 1911, p. 151.

PHYSICAL CHARACTERISTICS

Castor oil is very heavy. All oils and fats are lighter than water, but castor oil and cocoa butter have the highest specific gravity, that is, 0.970,[2] therefore nearly approaching the weight of water.

Because of its high specific gravity, its high viscosity, and its resistance to changes of temperature, it is used as a lubricant on heavy, quick running bearings. It resists heating better than most oils, and under the influence of cold does not solidify until a temperature of from 1 to 3 F. is reached, which makes it particularly desirable for aeroplanes. There is one mechanical application of this oil which is interesting to physicians. A small bottleful of castor oil poured between the drum and the break in an automobile, under the influence of the heat, will make the break grip more firmly. I learned this point from one of my chauffeurs, while mountain touring.

SOLUBILITY

There are qualities, however, other than its density and its action as a purgative, that make castor oil particularly interesting to dermatologists. For instance, it is peculiar in being soluble in alcohol, and it is because of this action that all the brillantines are concentrated solutions of castor oil in alcohol, perfumed in various ways.

In the practice of dermatology this solubility is important as it is frequently well to add castor oil to alcoholic lotions for the hair to prevent them abstracting too much oil, and thus unduly drying the hair. A very little, one-half dram or a dram to 4 ounces (2-4 gm. to 120 c.c.) is frequently enough. In patients in whom the hair is already too oily this addition is neither necessary nor desirable.

Castor oil also facilitates the solution of salicylic acid in oils and ointments and therefore renders it less irritating to the skin. In view of the great importance of salicylic acid in cutaneous therapeutics this pharmaceutic hint is correspondingly important. The salicylic acid should first be mixed with a little hot castor oil and then added to the other ingredients.

INCOMPATIBILITIES

There is an interesting pharmaceutical incompatability in a lotion containing sulphur, castor oil and spirits of camphor, written according to the following formula:

		gm. or c.c.
℞	Sulphuris precipitatae	
	Olei ricini.....āā	4 ℥ j
	Spiriti camphorae.....	16 ℥ ss
	Aquae .....ad	120 ℥ iv

2. Mathews, A. P.: Physiological Chemistry, William Wood & Co., 1916, p. 66.

This formula might readily be written, offhand, as a lotion for the scalp. It will form a spongy, light mass which quickly distributes itself when shaken, and as quickly again collects as a spongy mass, which is absolutely useless as a lotion. The oil and the spirits of camphor do not do this; neither does the sulphur and the oil, nor the sulphur and the camphor. Neither does the spongy mass form, if enough alcohol is added to take up all the oil.

Many physicians regard these pharmaceutic details as wholly appertaining to the profession of the druggist. This possibly would be a correct attitude if druggists were especially trained to attend to a dermatologist's work. This, however, is impossible, and furthermore, such liberty of changing the written prescription as this would entail would not be indulged in by the well-trained pharmacist, nor would it be tolerated by the physician.

SUMMARY

The main facts for a dermatologist to remember about castor oil are (1) its solubility in alcohol, and (2) the use of hot castor oil as a solvent for salicylic acid.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, Jan. 23, 1918

CHARLES M. WILLIAMS, M.D., *President*

CASE FOR DIAGNOSIS, SHOWN AT PREVIOUS MEETING. Presented by DR. G. H. FOX.

This was the case of a gentleman from Havana, whose affection had been diagnosed as lepra. The patient had worried over this a great deal and lost 20 or 30 pounds in weight. When first seen there was a general papular eruption over the body with large infiltrated patches on the trunk and extremities in which were a few discoid depressions of lighter hue. A brief examination showed that it was not lepra. At first glance the condition presented the appearance of a papular syphilid, but the eruption was not at all characteristic of this disease. It had persisted about three years without any particular change. The peculiar purplish hue of the eruption, its characteristic configuration on the forearms, and the depressions or "craters" in the thickened patches was strongly suggestive of lichen planus, but there were no well marked lichen planus papules. Dr. Heimann had made a biopsy and a diagnosis of sarcoid of Boeck. Thinking that mercury and iodid of potassium might be beneficial, even without a diagnosis of syphilis, the speaker gave the patient a course of "mixed treatment." As a result the notably thickened patches had flattened completely and the eruption was gradually fading. It was presented last month as a case for diagnosis, and to those who lacked implicit faith in the microscopic diagnosis it might still be so presented. The circular depressions on the thickened patches were still seen, but presented far less contrast. Examination of the blood showed nothing abnormal except a positive Wassermann reaction. The man's general condition was improved.

DISCUSSION

DR. FORDYCE said he had not seen the patient before, but that the condition suggested to him lichen planus, chiefly because of the distribution of the lesions and the pigmentation left behind. Nine years ago he had presented before the Society a case of extensive lichen planus which left behind an intense pigmentation. The patient was in his service at the City Hospital and later died. At necropsy it was found that marked changes had occurred in the suprarenal bodies, and he then thought that the pigmentation might have been due to the condition of the suprarenals.

DR. FOX thought it strange that some cases of lichen planus left pigmentation, while in others the lesions disappeared without any trace being left.

DR. WHITEHOUSE thought it was a case of lichen planus. The lesions were fairly typical. The fact that the condition had improved under mixed treatment rather confirmed that diagnosis than otherwise, in his opinion. In his experience mercury did have a favorable effect on lichen planus. The pigmentation on the wrist and the moderate itching would not militate against that diagnosis, for the pigmentation of the lesions around the wrist and over the body were fairly typical of lichen planus. The case bore a resemblance to one now in his service at the hospital, although the latter had not the large diffuse areas that this man had, but plaques, from ½ to ¾ inch wide, some

elliptical in shape and some linear, and leaving pigmentation resembling that exhibited by this man, on the front of the body.

DR. WISE said that the histologic picture was characteristic and could be interpreted only as that of the sarcoid of Boeck. The fact that the patient had received salvarsan was interesting from the point of view of the improvement of the skin, for Boeck emphasized the value of arsenic in the treatment of this type of sarcoid.

DR. FOX said that the improvement began before the single dose of salvarsan, which produced no evident result, and that the continued improvement was apparently the result of the mixed treatment.

DR. MACKEE said that when the patient was presented the previous month, the question of lichen planus was not seriously considered by the members present. The concensus of opinion was that, clinically, the affection belonged to the sarcoma group. The lesions were nodular and tumors ranging in size from a split pea to an adult palm, considerably elevated, and in some instances there was an annular or crateriform configuration. The surface of the lesions was smooth, whereas in hypertrophic lichen planus the surface was usually verrucous. The patient had never had any itching, which spoke against both lichen planus and mycosis fungoides.

The pigmentation was not typical of any particular entity but was similar to that seen in some cases of sarcoid and mycosis fungoides. In addition to the pigmentation there was a suggestion of a purplish or violaceous color as seen both in the Kaposi type of sarcoma and in lichen planus.

The speaker was astonished to see the improvement that had occurred. The lesions had disappeared completely, leaving the very marked pigmentation. Viewing the case for the first time one would think of the possibility of lichen planus on account of the widespread and pronounced pigmentation. While sarcoid tumors were likely to persist for many months, the speaker had seen them disappear in a month or two apparently under the influence of arsenic and even spontaneously. In fact, sarcoid was likely to act, in this respect, very much like Bazin's disease. In Dr. Fox's patient the rapid improvement was due apparently to either iodid or mercury or both, and the improvement might have been aided by the salvarsan which was given at a later period.

Clinically, there was nothing to rule out sarcoid excepting the wide distribution and the size and the number of the lesions and, perhaps, the fact that there was no remaining atrophy. Sarcoid produced both the nodular and plaque type of lesion, and at times they showed annular configuration. The speaker had studied the histologic material and could definitely rule out lichen planus. The lesion was a granuloma and resembled the tuberculosis group. The infiltration was broken up into small nodules in which there were changes in the collagen and an occasional giant cell. The slides were certainly not suggestive of leprosy. While the histology favored sarcoid it was impossible to rule out syphilis, and in view of the fact that the lesions disappeared so promptly under antisyphilitic treatment would also suggest this diagnosis in spite of the clinical picture and the long duration.

The speaker was inclined to look on the case as a very unusual and interesting example of sarcoid.

DR. FOX said that when he first showed the patient last month he had stated that a dermatologist in whom he had great confidence had made the diagnosis of sarcomatosis; but the purplish color, so characteristic of lichen planus and of no other disease, the configuration of the eruption on the forearm, and the fact that one or two lesions looked like obscure lichen planus papules, all pointed, in his opinion, to the diagnosis of chronic lichen planus. He had seen cases of this disease which, instead of running the usual acute course, had lasted for twenty years. The infiltration of the skin in the large patches might occur from the confluence of lesions, although he had never seen before

such marked thickening in lichen planus patches. Although the patient gave a positive Wassermann reaction, and in spite of the improvement under the mixed treatment, there was no feature of the eruption which could be positively called syphilitic. As for sarcoid, in the few cases which he had seen the lesions had been more or less of a subcutaneous nodular character, and the skin had been but slightly, if at all, reddened over the surface. He had never seen so extensive a case of sarcoid of Boeck as this and presenting this peculiar appearance. Sarcoid had been very persistent in every case that he had seen. In this case there had been no tendency after three years to show any evidence of disappearance, but improvement began immediately after the administration of the mercury and iodid of potash. Since years ago he gave up the study of microscopy for photography, he has been hesitant in speaking about microscopic examinations. He regretted that Dr. Heimann, who made the biopsy, was not present, but was still inclined to consider the case one of chronic lichen planus.

DR. FORDYCE said that in his opinion the possibility of syphilis may be considered, especially as it was reported that a positive Wassermann was present. If the histologic picture showed giant cells and vascular changes together with a positive Wassermann, and had furthermore improved under mixed treatment, there was certainly a possibility of syphilis being present. Tuberculosis of the skin was usually made worse by the iodid.

DR. FOX said that a man might have syphilis and yet have lichen planus or some other nonsyphilitic eruption. As for the fact that it disappeared under the treatment, all knew that many conditions that were not syphilitic will often disappear under iodid of potash—psoriasis, for instance. In this case there seemed to be none of the ordinary characteristics of syphilis in the appearance of the eruption. He would try to have another biopsy made, taking one of the papular lesions instead of a section from the edge of a patch, and see whether that looked like lichen planus.

DR. MACKEE said he recalled very clearly the specimen to which Dr. Fordyce referred, and histologically it had to be either tuberculosis or syphilis. The appearance was all in favor of tuberculosis.

DR. FOX, replying to Dr. MacKee's statement that the histologic examination indicated that it was either tuberculous or syphilitic, said that in that case he would be inclined to agree with Dr. Fordyce that it was syphilis.

NAIL AFFECTION, FOR DIAGNOSIS. Presented by DR. MACKEE.

This patient had been presented some months before when a complete history was given. As a child, the patient had some pustular affection of the bed of the nails, one after another being affected, each ending in the complete loss of the nail. The condition always had to be curetted and a minor operation performed. A period of relief followed, lasting for a number of years, and then the same affection occurred on the little finger of the left hand, and in spite of every effort to prevent it the nail was lost (antiseptics, permanganate of potash, salvarsan, roentgen ray, all failing). Two or three Wassermann tests were made and all were negative. Autogenous vaccines had also been made. The case was presented for diagnosis.

DISCUSSION

DR. KINGSBURY said that the treatment administered in the past had apparently been successful, and that this nail should be removed as the others had been. It was rather unusual to see fingers that have had nails removed appear so well as in this case. Often when an attempt was made to remove the nail some portion of it was left behind.

BAZIN'S DISEASE. Presented by DR. WISE for DR. FORDYCE.

The patient, E. McG., was a woman, aged 25, born in the United States, from Dr. Fordyce's clinic. She had suffered from hip trouble since she was 13 years of age. There was no tuberculosis in the family. She had suffered from Bazin's disease for a year and a half, the right leg only having been affected. The lesions, consisting of several large ulcers, strongly resembled gummas. The interesting question was whether there was any relation between the tuberculous hip and the Bazin's disease, both affecting the same extremity.

DERMATITIS PYOGENICA. Presented by DR. WISE for DR. FORDYCE.

The patient, E. H., was a married woman, aged 29. She had had three children and no miscarriages. She presented lesions of three weeks' duration, situated on the buttocks, chiefly at the intergluteal cleft and at the base of the spine. These lesions consisted of pea-sized papules with necrotic centers, and several ulcers with sharply defined, punched-out edges and necrotic bases, resembling gummas. The history with regard to syphilis was negative, as was also the Wassermann test.

DISCUSSION

DR. LANE thought it was a case of pyodermia. The lesions on the buttocks were fairly typical of it. The rather unusual appearance of the lesions in the intergluteal fold was probably to be accounted for by the moisture of the location and the rubbing together of the skin surfaces.

DR. KINGSBURY said his impression was the same as that expressed by Dr. Lane.

DR. WHITEHOUSE said that the lesions impressed him as being a broken down gummatous syphilid, although the duration of the condition was much too short for that. He was rather inclined to consider it a syphilitic condition.

DR. FORDYCE agreed with Dr. Lane and Dr. Kingsbury that the condition was a pyodermia probably due to a streptococcic infection. He suggested painting the lesions with tincture of iodin. Dr. McCormick of the English Army had recently published a very comprehensive article on cases of scabies complicated with streptococcic and staphylococcic infection. These cases were more severe than those encountered in civil life.

DR. MACKEE agreed with the diagnosis of pyodermia, probably following a pruritic eruption like scabies or pediculosis.

DR. WISE agreed with the diagnosis of pyogenic infection, and said it was rather strange that such conditions were not more often seen. He believed the dermatosis to be a type of echthyma.

MYCOSIS FUNGOIDES (?). Presented by DR. WISE for DR. FORDYCE.

The patient was a Russian, male, aged 42, and married. The duration of his dermatosis was about one year. He presented an eruption situated mainly on the trunk, arms, and thighs, consisting of many yellowish, reddish, and fawn-colored nummular macules, some of them slightly scaly, level with the skin, smooth and noninfiltrated. In isolated areas on the arms and thighs there were also several slightly raised and somewhat infiltrated papules, some of them arranged in a crescentic form. Itching was said to be intense, although scratch marks were not evident. At first glance, the diagnosis of parapsoriasis in patches was considered, and on further observation the possibility of mycosis fungoides was thought of. A biopsy failed to reveal any changes characteristic of either malady. The fact that the lesions rapidly faded under the roentgen-ray treatment, however, pointed strongly in favor of the diagnosis of mycosis fungoides, in the profungoid stage.

DISCUSSION

DR. FORDYCE said that Dr. Wise's argument that the condition had improved under roentgen-ray treatment rather strengthened the diagnosis of mycosis fungoides.

DR. MACKEE said that two biopsies had been made. The first showed only a slight inflammation. The second showed a beginning granuloma with a coat-sleeve infiltration around the vessels as seen in syphilis. Histologically it was impossible to make a diagnosis of mycosis fungoides.

Clinically the speaker thought that the disease was mycosis fungoides—premycosic stage—because there was considerable itching, the lesions were polymorphous in character, they were not permanent (they were constantly changing in configuration), and some were infiltrated.

DERMATITIS HERPETIFORMIS, SHOWING RESULT OF TREATMENT. Presented by DR. FORDYCE for DR. SHERWELL.

The patient had been shown at a previous meeting of the Society under a diagnosis of dermatitis herpetiformis, and was presented now to show the result of alterative antirheumatic treatment combined with pituitrin. He was entirely well.

NEURO-FIBROMA. Presented by DR. WISE.

The young man was a private patient, showing the early stages of multiple neuro-fibromatosis. There were only a few nodules on various parts of the body, and they seemed to be connected with the nerve trunks underneath. The patient was seeking to secure exemption from the draft, stating that when he walked fast and struck these nodules, intense pain was elicited. There were several nodules on the chest, back, and thighs, and considerable pain could be elicited by striking them suddenly and firmly. There were no "café au lait" spots. The history was negative. There was no similar condition in any other member of the family. Some of the tumors had been removed, simply to get rid of them, and no microscopic examination had been made. The man had not so far secured exemption.

DISCUSSION

DR. FORDYCE stated that the term "neuro-fibromatosus," which was generally used in referring to these conditions, was not correct in his opinion, for the majority of the tumors were not connected with the nerve sheaths though some of them might be. In some cases they started in the connective tissue about the skin follicles.

DR. FOX asked if the pain of which the man complained would not show some connection with the nerves.

DR. FORDYCE replied that the great majority of patients with von Recklinghausen's disease did not complain of pain.

DR. FOX said he thought it was a case of neuro-fibromas in connection with the nerves. Most of the cases that he had seen followed the course of the nerves, and all were intensely painful.

DR. FORDYCE said he had seen many cases of multiple fibromas without pain. There are all sorts of transitional cases between the two.

DR. FOX said he would call this a neuroma, although the term neuro-fibroma had been applied to them. The cases without pain he would call von Recklinghausen's disease. Von Reckinghausen's disease he would consider as the ordinary case of multiple fibroma associated with pigmentation of the skin and mental deficiency.

DR. WISE stated that the patient's affection was evidently a neuroma or neuro-fibroma. He had no visible cutaneous disease. Therefore this malady

must be distinguished from the cutaneous disease known as neuro-fibromatosis cutis, which was associated with the name of von Reckinghausen and which presented true cutaneous lesions with numerous "café au lait" macules.

ACRODERMATITIS CHRONICA ATROPHICANS. Presented by DR. WISE for DR. FORDYCE.

E. McC., aged 66, born in Ireland, came to Dr. Fordyce's clinic three weeks previously. A year ago his hands began to swell when he got up in the morning, and later became red. When presented there was marked edema, redness, and swelling of the dorsum of one hand, with a certain amount of smooth, velvety atrophy of the skin, extending up the forearms, almost to the elbows. The feet and legs were also affected, but had not the purplish appearance of the hands. The atrophy of the skin was evident on the backs of both hands and arms, but was more pronounced on the ulnar surface of the forearms than elsewhere. The Wassermann reaction was negative.

DISCUSSION

DR. WISE said he believed that the patient would ultimately present the anetodermia or cigarette paper wrinkling of the skin, as described by Pospelow and Jadassohn in this class of cases. Eventually the skin of the legs and arms would become hidebound and sclerodermatous in appearance. There was a great difference between the transparent, smooth, velvety skin of acrodermatitis atrophicans and true scleroderma, although a sclerodermatous change frequently manifested itself in cases of acrodermatitis atrophicans, especially around the ankle joints. In the patient described by Dr. Fordyce, a woman affected with this clinical type of cutaneous atrophy, there were no sclerodermatous changes, the entire process having been one of atrophy.

DR. KINGSBURY said that it was too early to reach any definite conclusion as to the diagnosis. It was a very interesting case for study.

DR. WHITEHOUSE said it would seem to be one of those cases described as acrodermatitis atrophicans, but he agreed with Dr. Kingsbury that it was too soon to make a definite diagnosis.

DR. FOX said that as he had before maintained, he considered the name an abomination. The condition was one that all had been familiar with for years—with erythematous lesions, not always on the hands and feet, next swelling of the skin, and then the hidebound condition of scleroderma, followed by atrophy. He had photographed the condition repeatedly on the thighs. This was exactly the same disease, and why it should be called by a long three-barrelled name he could not understand.

DR. FORDYCE asked if Dr. Fox would identify an atrophy of the skin with scleroderma.

DR. FOX said that atrophy often coexisted with scleroderma. The condition had a variety of names, but it was the same disease—whether it was on the hands and feet alone, or on the thighs, or body. One would not call the condition on the thigh an acrodermatitis chronica atrophicans, although the pathologic process was the same and there was the same sequence of conditions.

DR. FORDYCE said that the acrodermatitis chronica or symmetrical cutaneous atrophy was a very definite condition. It began on the fingers and sometimes involved the hands and arms, but these patients had nothing to suggest scleroderma.

DR. FOX repiled that this case in his opinion was one of scleroderma, and he ventured to predict that in a short time the man would have the hidebound condition, etc.

DR. FORDYCE said he had watched a patient for years and saw first the edema, the redness, and then the atrophy.

DR. WISE said, in connection with Dr. FOX's remarks, that acrodermatitis chronica atrophicans was a clinical entity, differing in many ways from diffuse atrophy of the skin and from scleroderma. The chief differentiating points in acrodermatitis atrophicans were as follows: The disease was peculiar in that it almost invariably began on the hands and feet; the affected skin eventually became glossy, velvety, smooth and translucent like advanced senile atrophy. The veins shone through the skin. Sometimes sclerodermatous changes supervened. In true scleroderma the skin was "hidebound," dense, hard and inelastic, and could not be lifted from the subcutaneous tissues. The veins did not shimmer through the skin. In acrodermatitis chronica atrophicans, large fibrous nodules developed, late in the disease, at the knees and elbows. Such a case was ably described in the *Urologic and Cutaneous Review*, by Ketron of Baltimore. In the speaker's experience, such nodules were encountered neither in diffuse atrophy of the skin, nor in diffuse scleroderma.

DR. FOX said that on the thighs we had the same erythematous swelling at the beginning, and in a short time we had the hidebound condition of scleroderma, and it ended in the atrophic wrinklings of the skin. Sometimes the sclerodermatous stage may be absent, and you simply had the wrinkling, following the edematous condition. He stated, further, that he was willing to admit that Dr. Wise had studied the condition and read more carefully than he had done, but it seemed to him there was a tendency in modern dermatology to take a disease, as one might take psoriasis, for example, and selecting conditions on certain parts of the body, call them by different names. Yet, it would still be ordinary psoriasis.

HODGKIN'S DISEASE. Presented by DR. WISE for DR. SCHWARTZ.

The patient was a young man, single, born in Russia, and had suffered with the condition for seven months. He presented marked adenopathy of the neck, axillae and groins, together with a papular eruption of the body, most pronounced on the trunk, which showed evidences of much scratching.

DISCUSSION

DR. WHITEHOUSE said that Dr. Fordyce had brought up the matter of the eruption in this case, and he would recall to his attention a case of lymphatic leukemia which was much like this which he presented a year or two ago. The itching, the grouping, and the pigmentation were clinically those belonging to a dermatitis herpetiformis, and Dr. Fordyce in discussing that case believed as he did—that it was part of the Hodgkin's disease.

DR. FORDYCE agreed with Dr. Whitehouse that the pigmentation was part of the Hodgkin's disease. He had seen it in one other case of Hodgkin's disease, and it was described in most of the textbooks as a possible complication.

DR. LANE asked if the eruption was not more often scattered and discrete, and less diffuse than this. Was not this more the type of arsenical pigmentation?

DR. FORDYCE replied in the affirmative, but said that patients did have pigmented lesions in Hodgkin's disease.

DR. MACKEE said that he regarded the pigmentation as being due to arsenic. It was both widespread and mottled. The speaker thought that arsenic was carelessly employed by dermatologists. It was a valuable remedy, but could only accomplish a certain amount of good. On account of the possibility of serious sequelae, arsenic should not be employed too steadily over long periods. The main trouble seemed to be in letting the patient know that arsenic was being administered. If the disease were one like dermatitis herpetiformis, the patient might take arsenic at intervals for years without the permission of the dermatologist. The speaker employed arsenic very cautiously and never allowed the patient to know of its administration, or, if he did know, he was cautioned against taking it without permission and only in the doses prescribed.

In Hodgkin's disease the results following roentgen-ray treatment were very good. The deep technic should be employed and great care taken not to injure the skin.

DR. FOX said he was gratified to hear Dr. MacKee's remarks about arsenic, and that he had sometimes wished that a law should be passed preventing physicians from using this drug. He had always claimed that it was one of the most powerful drugs we had, but that it very frequently did more harm than good, and that it should not be prescribed for skin diseases except when needed as a nerve tonic. The common habit of many physicians of prescribing it for all dermatoses, just as quinin was prescribed for chills and fever, had done much harm.

DR. FORDYCE said that he had noted the occurrence of keratosis on the palms and soles after the administration of salvarsan. It sometimes occurred independently of a generalized exfoliative dermatitis; at other times, it persisted after the disappearance of the generalized dermatitis.

DR. FOX said that in these cases of Hodgkin's disease arsenic was generally given in such large doses that it was difficult to say whether the pigmentation was due to the disease or to the arsenic.

Regular Meeting, Feb. 27, 1918

JAS. C. JOHNSTON, M.D., *President*

MILIARY PAPULAR SYPHILID. Presented by DR. WISE for DR. FORDYCE.

The patient was a woman, aged 25, single, who for three weeks had had an eruption on the face and upper part of the trunk. The facial eruption consisted of closely set pinhead to barleycorn-sized nodules, many of which coalesced to form solid plaques which implicated the skin of the nose, chin and cheeks. On the upper part of the trunk and extremities the skin exhibited numerous lichenlike miliary papules, occurring as scattered lesions and in groups. Here and there several lenticular nodules were surrounded by smaller miliary papules, forming a corymbiform eruption. The patient denied sexual relations, and to all appearances had acquired the infection innocently. Her family physician had diagnosed the condition as one of erysipelas, and had treated her for that disease for a week prior to her admission to the clinic.

LEPRA. PRESENTED BY DR. WISE.

This was a private patient, a woman, aged 58, born in Bavaria, but who had been living in New York for thirty years with the exception of four months which she had recently spent in Los Angles, Calif. It was not ascertained how or where she acquired the disease. The lesions had been present for about six years, but the condition was not recognized until recently. The lesions were chiefly of the nodular type on the face; there were some annular lesions on the legs. The patient also had anesthesia, and beginning atrophy of one hand. When picking up things she frequently dropped them unconsciously. A biopsy was made in Los Angeles, and lepra bacilli were found.

CASE FOR DIAGNOSIS (SARCOID?). Presented by DR. G. H. FOX.

The patient was a Cuban, and the possibilities of lepra, syphilis, mycosis fungoides, sarcoid and lichen planus had been discussed. Under mercury and iodid of potassium the large thickened masses had disappeared entirely and the eruption had flattened, leaving considerable pigmentation. The patient was presented on two previous occasions.

DISCUSSION

DR. FOX said that he was still inclined to the diagnosis of lichen planus, although Dr. Heimann had made a second biopsy, this time taking a small lesion instead of a section from a large thickened mass, but had found no evidence of lichen planus.

The speaker said he hated to doubt what was found by microscopic examination, but all knew that pathologists sometimes differed in their findings and at times we were obliged to fall back on the clinical diagnosis. In this case there were several points essentially characteristic of lichen planus, namely, the purplish hue of the eruption which he had never seen in any other skin disease, the configuration of the lesions on the forearms which all admitted was typical of lichen planus, and the presence still of flattened, umbilicated lesions which, if not typical, were very suggestive of lichen planus papules. The "craters," or circular depressions of lighter color than the surrounding skin which were seen in a few of the thickened patches, he had never observed except in two diseases—leprosy and lichen planus. These had almost disappeared. The marked thickening of the skin in patches as large as the palm he had never seen before in lichen planus. The resulting pigmentation might indicate syphilis as well as lichen planus, and the rapid disappearance of the eruption under mercury would naturally suggest this diagnosis; but the condition had persisted with little or no change for three years and there were no characteristic syphilitic lesions. Mercury might also cure a sarcoid, it is claimed, but the few cases he had seen had not yielded to such treatment. It could hardly be a case of tuberculosis, as that would not yield so rapidly to "mixed treatment." The only way the diagnosis could be settled, in his opinion, was to await developments and see whether or not the patient has a relapse of typical lichen planus during the next year or so.

DR. WISE said that he based his diagnosis of Boeck's sarcoid chiefly on the histological structure of a specimen derived from one of the lesions. Further, he said that the first case which Boeck described and illustrated in THE JOURNAL somewhat resembled this case, from the clinical standpoint.

DR. HEIMANN said that the first specimen which Dr. Fox sent to the laboratory showed the histologic structure of sarcoid. In studying the literature he found that Hallopeau and Boeck had each described similar cases characterized by large plaque-shaped lesions on the back. Microscopically the lesions suggested only sarcoid and had none of the characteristic features of lichen planus. The second biopsy showed less of the infiltration but a large increase in the vascular structures, and a slight perivascular infiltration of the same type found in the first biopsy. Clinically he did not think the remaining pigmentation was so much due to the deposition of melanin as to a dilatation of the vessels. The skin over all the lesions could be blanched on pressure, which would not be the case in lichen planus. Sarcoid sometimes disappeared spontaneously. He understood that arsenic, roentgen ray, mixed treatment, etc., had been employed.

LICHEN PLANUS. Presented by DR. HEIMANN.

The patient presented lichen planus lesions on the hands. For twenty years, more or less, he had had psoriasis, of which he presented typical lesions on his thigh. Two months ago the lesions on the palms appeared and subsequently a few lesions on the wrists. The lesions on the palms had characteristics suggesting lichen planus, but these were more marked on the wrists. The buccal mucous membrane was free of lesions, but examination of the prepuce showed lichen papules, of which the man was not aware. A biopsy had been made and revealed typical lichen planus.

HYPERTROPHIC LICHEN PLANUS. Presented by DR. WISE for DR. FORDYCE.

The patient was an Austrian, aged 48, with a negative personal history. He presented numerous deeply pigmented, isolated and confluent papular lesions, located chiefly on the lower part of the back and the backs of the thighs. The lesions were dark brown in color, shiny, irregular in outline, and topped with striated scales, giving the affected skin a roughened appearance. Many of the lesions were circinate in outline, the circles consisting of closely set papular elements. The interior of some of the circinate lesions presented evidences of atrophy, with brownish pigmentation. The mucosae were unaffected. The duration of the eruption was six months.

SARCOID. Presented by DR. KINGSBURY.

The patient was a young woman, aged 18, with lesions on the right cheek of five months' duration. These consisted of several dark red, slightly raised, sharply outlined, smooth, somewhat edematous and indurated plaques, resembling nodular lupus erythematosus.

DISCUSSION

DR. FOX said that in the cases of sarcoid he had seen the disease had more the character of a subcutaneous tumor with a comparatively smooth skin over it. Although in this case there was a decided thickening of the skin, it seemed to be too superficial a condition to be termed sarcoid. He was inclined to consider the condition to be lupus erythematosus.

DR. WHITEHOUSE said that he considered the diagnosis lay between sarcoid and lupus erythematosus. He had always observed, as Dr. Fox had said, that sarcoid lesions were rarely of this superficial discoid type, neither had sarcoid the pitting and the slight atrophy seen in this instance. There was also an adherent scale in one part which if detached might present the characteristic prolongations into follicles. In his opinion the clinical features were more in favor of lupus erythematosus than sarcoid.

DR. HEIMANN said that it was often difficult to differentiate clinically between the two conditions. In some points the case resembled sarcoid more than lupus, but, as Dr. Fox had said, it seemed too superficial for sarcoid, and, as Dr. Whitehouse stated, too deep for lupus erythematosus. There were two types of sarcoid, that of Boeck which was dermal and a hypodermal type or deep form. The latter conformed to the description given by Dr. Fox—the skin stretched and elevated over a deep infiltration. The speaker inclined, however, to the diagnosis of sarcoid of the superficial variety rather than to lupus erythematosus, though the two conditions were very closely related.

DR. SHERWELL said that at first he thought it was lupus erythematosus, but afterward recalled the case of a Scandinavian whom he had presented before the Society, and whom Dr. Clark had treated with the roentgen ray without results, save destructive. The man was 40 years of age and had the same kind of lesions but more pronounced, and in the same situation—both cheeks over the malar prominences. He disappeared for awhile, but the speaker had heard from him recently and he was rather worse; the roentgen ray did not prove beneficial and ulcerations had developed where the roentgen ray was applied. The general consensus on that case, when shown two or three times at Society meetings, was sarcoid; from the apparent analogy he should be inclined to the same diagnosis in the present case.

DR. WISE agreed with the diagnosis as presented, and with the remarks made by Dr. Heimann. It had been his experience that in those cases in which the diagnosis of lupus erythematosus could not be made outright and without hesitation, a biopsy would almost constantly reveal the lesion in question to be one of Boeck's sarcoid.

DR. MACKEE agreed that it was often difficult and at times impossible to differentiate clinically between lupus erythematosus and sarcoid of the superficial type. The speaker had seen patients who exhibited lesions of both diseases. A short time previously there was a patient at Dr. Fordyce's clinic with a typical butterfly lupus erythematosus of the nose and cheeks, and lesions of sarcoid on the chest and arms. In the case under discussion the speaker was in doubt about the diagnosis. The adherent, thickened, horny layer suggested lupus erythematosus. On the other hand, the patch was composed of three small lesions which were grouped in a circinate manner. This was suggestive of sarcoid.

DR. KINGSBURY said it was clearly a borderline case, and should be kept under observation before making a positive diagnosis. He concurred with the remarks made by Dr. Whitehouse and Dr. Fox, and also the point made by Dr. MacKee of the distinct plaques tending to form a circle. He had brought the case up for consideration, as he had hoped also to show another case of definite sarcoid.

CASE FOR DIAGNOSIS (FOLLICULITIS OR SYCOSIS?). Presented by DR. WISE for DR. FORDYCE.

The patient was a man, aged 30, who for two years had been troubled with a follicular eruption of the beard and anterior portion of the scalp. There was no evidence of pus formation or of central necrosis, the lesions being small and dry. The case was presented on account of its resemblance, in the scalp to acne varioliformis, and in the beard to sycosis.

DISCUSSION

DR. FOX said that if the folliculitis had been confined to the cheeks no one would have thought of anything but sycosis. Sycosis of the scalp was rare, but was seen occasionally, usually in conjunction with sycosis of the face. It could hardly be acne varioliformis, as there would have been some scars by this time. If he were forced to make a diagnosis he would call it sycosis.

DR. WHITEHOUSE thought it was a case of folliculitis, probably one of the class he had spoken of more than once, which he called "pickers," where the process is kept up by continued picking at the affected region. At one time he had a case that could hardly be differentiated from sycosis. It was finally found that the patient had a notion that the hairs were turning inward and that the only thing to do was to pick them out, and he kept a pair of forceps and scissors for this purpose until he had actually dulled the scissors. When the instruments were taken away from him, the whole condition cleared up—simply by checking the irritation. The lesions in Dr. Wise's case were all picked. He did not see any evidence of acne varioliformis.

DR. SHERWELL asked if the formation of pus was not a sine qua non in sycosis. There was no evidence of that in this case. It seemed to him to be a destructive folliculitis of some kind. He had never seen a case of sycosis in which there was not some pus—sometimes large quantities, sometimes less.

DR. MACKEE said the condition was certainly a chronic folliculitis, and the fact that there were no pustules would not necessarily negative the diagnosis of sycosis vulgaris.

DR. FOX, referring to Dr. Sherwell's inquiry about suppuration in sycosis, said that years ago when he was studying sycosis and trying to find a case with hairs penetrating the pustules for a typical photograph, he had examined scores of cases, many of which showed no pustules at all, and was then impressed with the fact that there was often a persistent folliculitis without the formation of pustules.

DR. WINFIELD agreed with what Dr. Fox had said. He had often watched cases of sycosis and found no pus at any time.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Dec. 18, 1917

WILLIAM ALLEN PUSEY, M.D., *President*

CASE FOR DIAGNOSIS. Presented by DR. SENEAR for DR. PUSEY.

The patient was a man, aged 32, who was presented because of a persistent eruption which had not responded to treatment. The disorder was of one and one-half years' duration. When first seen many of the lesions were urticarial in type, but in the present attack all the lesions were flat and erythematous. Likewise, when first seen the patient had a few scattered vesicular lesions on the face, but these cleared up under autoserum therapy and had not since recurred. Ordinary methods of treatment were unavailing but the disorder practically disappeared under five injections of autoserum treatment, and did not recur for five months. The eruption apparently had no relation to foods. It was formerly accompanied by severe itching which was worse at night but this was not so pronounced in the present attack. As a boy he had urticaria each summer for years.

DISCUSSION

DR. FOERSTER considered it one of the not infrequent urticarial types of dermatitis herpetiformis. The persistence of the ring type of the eruption and the duration would also speak for that diagnosis.

DR. ZEISLER said that at first glance he thought of pityriasis rosea but the duration of the disorder excluded that diagnosis. The lesions were more like the persistent type of urticaria than anything else.

DR. LIEBERTHAL had seen the case eighteen months previously and the lesions were distinctly those of urticaria, but the persistence of some of them and the occurrence of a vesicular eruption on the face from time to time made one think of dermatitis herpetiformis. He believed the further study of the case would be exceedingly interesting.

DR. SENEAR stated that the case at first was distinctly urticarial, the lesions for the most part being erythematous, but at present while the skin reacted to trauma very easily there were not many lesions of the urticarial type left. He was inclined to believe that it was a case of dermatitis herpetiformis.

LEPRA ANESTHETICA. Presented by DR. HARRIS.

The patient was a man, aged 29, a native of South America, who presented typical lesions which were of eighteen months' duration. A good deal of anesthesia to heat and pain was present. The trouble started as a small red spot on the palm, rather quickly spread to the face, then appeared on the left thigh and both lower legs, accompanied by anesthesia and pigmentation.

The patient showed the leonine facies, and areas of infiltration and pigmentation over the trunk and extremities. There were areas of anesthesia and rather marked atrophy of the interosseous muscles.

DISCUSSION

DR. BEESON considered it a very interesting case of a type which was not seen very often in our country.

DR. HARRIS thought the case interesting because the patient had been examined by five different physicians in Chicago and the diagnosis was not ascertained until made by a neurologist.

DERMATITIS EXFOLIATIVA. Presented by DR. HARRIS for DR. MCEWEN.

The patient was a man, aged 52, who had been in the hospital about three months previously. The disorder had existed for two years. It started in the left groin, then appeared behind the knee, then under the arms and finally all over the body. It was accompanied by itching which was worse in the day

time and more pronounced in the summer than in the winter. At the time of presentation the patient showed a generalized dermatitis with exfoliation and generalized lymph adenopathy. The skin was of a brownish-red color.

DISCUSSION

DR. SCHAFFNER had considered the possibility of a leukemia with skin changes, or an exfoliative dermatitis of the type of pityriasis rubra—Hebra.

DR. BEESON believed that pityriasis rubra would have to be considered.

DR. HARRIS called attention to the similarity between this case and that of the Bulgarian shown at a previous meeting, who presented the same thickening of the skin. That patient had practically cleared up on a low nitrogenous diet during the last eight months. He had the same adenopathy and the lesions displayed the same tendency to weep, but he had disturbances of pigmentation also.

FAVUS. Presented by DR. STILLIANS.

The patient was the little boy who was shown at the October meeting. He was exhibited again to show the condition as it was originally. When ointment was used the trouble almost entirely disappeared. The treatment was stopped and within a few days the whole head was again coated over with crusts, matting the hair together, and favus cups had been found, though they were not found before. (Photographs and specimens were exhibited.)

DISCUSSION

DR. HARRIS asked if anybody had seen a case of favus appearing as a scaly dermatitis without any cups and no loss of hair. The hair simply got dry and was matted together.

DR. LIEBERTHAL said he had seen only a few cases of favus in Chicago, perhaps five or six, and all had occurred in American children whose people had lived in this country for generations. He had seen cases during his early days in Europe in which the hair matted together because the favus was combined with an extensive seborrhea.

DR. HARRIS said that in this case sulphur ointment would take the lesions off and then when treatment was stopped it would recur in a very few days. There were originally epithelial cells and mycelium, but no weeping and no scutulae.

DR. STILLIANS stated that the scales were not greasy but were dry and very adherent. When removed they crumbled up like soft mortar.

SCALY PATCHES OF THE SCALP. Presented by DR. HARRIS.

The patient was a woman, aged 51, with a scaly patch 2½ inches in diameter on the posterior part of the scalp which had been present for twenty-five years. The lesion was markedly hyperkeratotic and remained in one location, gradually getting a little larger. It was covered with thick white scales which were very adherent and on removal left a bleeding area.

DISCUSSION

DR. FISCHKIN thought it appeared to be a superficial irritation of the skin. The lesions were not deep and were associated all the time with an inflammatory condition of the skin. He believed it was a persistent eczema of the scalp which had apparently never been treated. He thought that persistent treatment and proper care would probably clear it up.

DR. FOERSTER thought it was one of those peculiar, persistent, scaly, inflammatory patches on the scalp, or often just at the margin of the scalp, which were extremely resistant to treatment. He had never been able to satis-

factorily classify them; the resemblance to eczema was marked at times, but the entire lack of response to treatment was a differentiating feature. The speaker had shown a similar case in a man, but he thought in that case there was much more hyperkeratosis than in the present patient, and a great deal less infiltration and inflammation with considerable loss of hair. He believed these cases were two types of the same condition, differing only in degree.

DR. MACKEY thought the traumatic element was a large factor in the etiology of such conditions. In his observation the patients usually had a nervous habit of oftentimes unconsciously scratching, and the degree of thickening of infiltration depended on the persistency of this scratching. He was inclined to look on the affection as belonging to the neurodermatoses.

DR. SENEAR agreed with Dr. Foerster that the lesion was pruritic, because the woman said that she pulled the hairs out.

DR. ZEISLER thought it was an exaggerated case of eczema nuchae such as was often seen in women at the nape of the neck.

DR. LIEBERTHAL believed the cases should be classed as eczema. They were very resistant to treatment but were sometimes cleared up. He had applied potassium hydrate in some of the cases, had used the compound chrysarobin ointment, and applied the ultraviolet light to the patch. Considerable irritation was produced which afterward subsided. He thought intensive treatment would control these cases in most instances.

DR. HARRIS said he showed the patient because the condition was exactly parallel to that in a patient whom he presented before the American Dermatological Association three years ago. He had treated the patient for a year but did not get results and then Dr. Pusey had treated her for a year. The lesions had remained in about the same location. In the case of the man, he said he had used all sorts of treatment and in that case the scales came off easily. A mixture of 10 per cent. sulphur and 15 per cent. salicylic acid had helped but immediately on stopping treatment the whole process returned. He had also used the ultraviolet ray, even to the point of blistering the skin. The lesions improved temporarily but in a couple of months they recurred. The characteristic thing was the sharply defined patch, somewhat infiltrated, with a silver white scale which was very adherent. He did not believe it was lichen chronicus or an eczema nuchae, for these conditions disappeared very readily under the ultraviolet light or some stimulating application, but this did not. Itching was not a prominent factor in these cases while in the lichen chronica nuchae it was.

BLASTOMYCOSIS. Presented by DR. STILLIANS.

The patient was a colored man, aged 38. The lesions began on the scrotum eleven years ago and progressed upward to the middle of the abdomen and backward to the gluteal region. He had been in the hospital at one time for fourteen months, leaving three months previously with only a few small unhealed areas At the time of presentation he showed a number of large lesions which varied in size up to several inches in diameter. The active lesions were at the borders of the area, the center occupied by a deep contractile scar A small lesion formerly on the tip of the right thumb had not recurred.

DERMATITIS HERPETIFORMIS. Presented by DR. HARRIS.

The patient was a young colored woman with generalized dermatitis who was shown at the November meeting.

The eruption had cleared up after that meeting and then another attack had broken out which showed the erythematous urticarial lesions of the dermatitis herpetiformis.

DISCUSSION

DR. FISCHKIN thought that many cases on the borderline were hard to diagnose, but here there was itching and the lesions were grouped and it looked to him like a dermatitis herpetiformis of the bullous type.

CHICAGO DERMATOLOGICAL SOCIETY

Annual Meeting, Jan. 17, 1918

PRESIDENT'S ADDRESS

(*Abstract*)

BULLOUS AFFECTIONS OF THE SKIN WITH SPECIAL REFERENCE TO DERMATITIS HERPETIFORMIS, HERPES GESTATIONIS AND PEMPHIGUS VULGARIS

David Lieberthal, M.D.

After citing the histories of numerous cases of the three above-named diseases, the speaker considered diagnostic points and treatment. The most frequent type of dermatitis herpetiformis was the vesicular. The apparently angular bases of the vesicles, on which so much stress was laid, was the result of confluence of very minute round vesicles. In the bullous variety of cases there was a preponderance of vesicular lesions. Affection of the mouth in dermatitis herpetiformis occurred only after skin manifestations had preceded. Grave forms of the diseases with a fatal result were observed but rarely. In these a distinction from pemphigus vulgaris might prove quite difficult.

In herpes gestationis the purely vesicular form was the more frequently observed. Although these cases were classed under dermatitis herpetiformis, yet they formed a separate group on account of difference in their course. After termination of pregnancy the skin healed, and only with subsequent pregnancies did the cutaneous affection recur. Here was suggested a toxic item, developed during pregnancy, as being the causative agent. One of the cases cited, in a pregnant woman presenting vesicles and bullae in great number around the genitals, anterior aspect of thighs and abdomen, was dwelt on at greater length. Here were observed grayish brown vegetating masses on the bases of blebs. Some of the blebs and vesicles showed turbid contents. On account of these two items two divergent diagnoses, of pemphigus vegetans and of impetigo herpetiformis were offered. Against the first must be said that bullous lesions of various diseases might be followed by vegetations without being pemphigus vegetans. Pemphigus vegetans was accompanied by grave systemic symptoms and terminated fatally. As to impetigo herpetiformis there were present at all times groups and bands of pinhead-sized pustules (and pustules they were at the inception). These coalesced and became crusted. The process spread peripherally by the apposition of new groups of pustules of the same size. Even should it be admitted that cases with mixed lesions, vesicles, blebs and pustules occurred, yet the initial lesions of minute pustules must always be present and these in the majority. The patients with impetigo herpetiformis were prostrated, with chills and high temperature going hand in hand with the eruptions. The mouth became affected subsequently and the patient died, as a rule.

The diagnosis of pemphigus at times offered difficulties. Attention was here called again to the cases with vesicular and bullous affection of the mouth preceding by many months the appearance of lesions on the skin, especially one case of a girl of 24, who showed besides the lesions in the mouth, erythematous patches on the abdomen and thighs and on these, groups of vesicles a number of months before any bullae developed on the skin. At that stage a dermatitis herpetiformis was suggested. The speaker, at that time, declined to commit himself but intimated the possibility of a pemphigus. It was advisable to be guarded in making a diagnosis of pemphigus at the first examination, except if the case were a perfectly pronounced one. It was far

more reasonable, in even slightly doubtful cases, to defer a definite diagnosis. The speaker said that he had not been fortunate enough to see any case of benign pemphigus. In every case of decided pemphigus he had given a bad prognosis, and the further events proved this to have been correct. The most important thing to do was to make the life of these sufferers as bearable as possible. Of internal remedies none had given any satisfaction in pemphigus, even arsenic and quinin giving no results in his hands, although in dermatitis herpetiformis arsenic proved of benefit. Of local applications he found of service cooling mixtures of water, vaselin and lanolin. But the treatment of choice was the continuous bath. The speaker kept one patient with pemphigus foliaceus in perfect comfort in the bath for nine consecutive months. Unfortunately few hospitals were equipped with such apparatus which would serve also for other diseases with extensive cutaneous lesions. The speaker had no personal experience with salvarsan or serum treatment in pemphigus, although there were cases successfully treated by both on record. In dermatitis herpetiformis the serum treatment was generally accepted as beneficial. And here was opened a field for fruitful research by systematic examination of the serum before and the blood of the patients after injections, which might disclose chemical or other changes and give a scientific basis for this method.

DISCUSSION

DR. ORMSBY said the subject of vesicular and bullous dermatoses was a very large one, but Dr. Lieberthal's exhibition of the subject was very good. One or two points he thought were of particular value; the first was the question of the vegetating lesions in the patient he mentioned. They had had considerable experience in vegetating lesions occurring in dermatitis herpetiformis. He had seen the patient referred to and she had no sign of impetigo herpetiformis. He had never seen a case and thought they were very rare; Dr. Hyde had reported one case a number of years ago. He believed that the disorder was characterized by small pustules and unless they were present that diagnosis could not be made. The appearance of the mucous membranes must also be impressed on them. They had seen a number of cases at the County Hospital where the diagnosis had been made before any lesions appeared on the skin. He also believed the mucous membrane type of cases were very grave. He thought there was a group of acute cases of pemphigus, but these cases were practically infectious bullous dermatoses, one of them being the type which followed vaccination, and the other, the butcher type which followed some sort of injury. Whether these really should be classed as pemphigus was a question which was still to be decided. They were cases of bullous dermatitis in which the patient commonly succumbed.

As to the other question, the subjective symptoms; he believed that the burning sensation which occurred in dermatitis herpetiformis was not sufficiently emphasized. They itched a great deal and the burning sensation was a very pronounced feature.

They had had considerable experience with autoserum in these cases and it had been of some value. He believed arsenic was the best remedy, but in the long run keratoses appeared and became pigmented and it was questionable whether it was best to have prolonged the use of the remedy or not. He had patients now who were "fiends"—they would rather have the keratoses and pigmentation than the disease. Some of them averaged 15 drops of Fowler's solution or the liquor arsenicalis; in this way the cases could be kept entirely under control. A number of cases apparently recovered but the arsenic had to be continued and the treatment was unsatisfactory on that account although it would absolutely control the symptoms.

Their experience with arsenic in pemphigus was unsatisfactory. The patients who had been given that treatment had eventually succumbed to the disease.

As to facilities for a continuous water bath, Dr. Lieberthal had not applied to the Presbyterian Hospital. That hospital had a thearpeutic department and

for some years they had treated all their cases that needed it in that manner. The department had been established there for at least ten years. He believed that any paper of this sort which would bring out a discussion on such a group of diseases was important, and he believed with Dr. Lieberthal that in some of the cases diagnosis must be deferred for a considerable time, but after a reasonable time the diagnosis could be arrived at. The therapeutic measures were entirely inadequate to meet the situation.

DR. STOKES said that after listening to Dr. Ormsby's discussion there was not much a younger and less experienced man could add.

His interest in the dermatitis herpetiformis group of dermatoses was aroused by seeing on Dr. Wile's service an example of impetigo herpetiformis in a woman who at the time of her death had a four weeks' old child. The disease came on during pregnancy and presented the peculiar stellate flaccid pustules from the very onset of the disease. His interest had been further stimulated by the striking histopathologic resemblance between the lesion of dermatitis herpetiformis and that produced by an extrinsic toxic agent, the poison of the black fly met with in the north woods. The general below-par condition of patients with dermatitis herpetiformis had repeatedly impressed him. Although they were often spoken of as healthy there was apt to be a peculiar pallor and a pinched appearance about the face. None had ever seemed to him to be constitutionally entirely normal.

He had been impressed from the etiologic standpoint with the influence of the nervous type of makeup and of the nervous strain in the development of dermatitis herpetiformis. The nervousness was not to be confused with that due to the itching and loss of sleep in the attack itself. He had had intelligent observers say that they could bring on an attack by a prolonged mental and nervous strain. The favorable results which would frequently be brought about by inducing the patients to take up an outdoor life were rather interesting. Some indoor workers in his experience had greatly reduced the frequency of their exacerbations by taking up life on a ranch.

He had been impressed many times as had all those attending the sessions of the Society, with the relationship so often emphasized by Dr. Pusey between dermatitis herpetiformis, urticarias, and erythema multiforme quite as much as between the dermatitis herpetiformis and pemphigus.

In the one case of pemphigus vegetans which he had thus far had an opportunity of studying, he attempted to make anaerobic cultures for the bullae without result. Quinin given intravenously by the method of Lesczynski—1½ or even 2 gm. were without effect. Salvarsan and the administration of arsenic were equally ineffective. The continuous bath gave the young woman temporary relief.

He was interested in hearing Dr. Ormsby mention arsenic "fiends." He thought that such a mental state sometimes developed among psoriatics as well as among patients with dermatitis herpetiformis. They got to the point at which they preferred the ill effects of arsenic to the conditions it managed.

DR. FOERSTER said that Dr. Stokes had suggested a point which had always been of great interest to him, the diagnosis of these bullous lesions of the skin from the bullous type of erythema multiforme. He had recently had an opportunity to investigate several of these cases with the view of determining the possible presence of an acidosis. A typical case of recurrent erythema iris involving the hands and forearms, with isolated lesions on the other extremities and occasionally on the mucous surface of the lips, a condition existing for a number of years, was investigated for its alkali reserve content, which was found to be very low. The patient was placed on alkalies and immediately the condition cleared completely. On cutting down the alkali the lesions promptly returned, and they reappeared and disappeared at will just as the amount of alkali was increased or withdrawn. Shortly after that he saw a case of what he regarded as an erythema bullosum toxicum, in a child about six years of age, following scarlet fever. In this instance the lesions were those which

would be regarded as typical of pemphigus. They were large groups of bullae, arising suddenly from skin which had been absolutely clear. Over night a group of hazel-nut to olive-size bullae would appear on different parts of the body. The condition persisted for seven months with numerous sharp rises of temperature. It was difficult to investigate the alkali reserve, as the child was very small, but an accurate result was finally obtained and it was found to be very low. An attempt to determine the alkali reserve by noting the response of the highly acid urine to the administration of sodium bicarbonate had been made, but it was almost impossible to get the urine alkaline. After it was determined by the Rowntree method that the carbon dioxid tension of the alveolar air was low (28-normal between 40-50) large doses of soda were given and the bullous lesions gradually grew less in number and size and then ceased altogether. When treatment was suspended for a while the lesions reappeared and on reinstating the alkali treatment they vanished again. They had now remained away for three months, during all of which time the urine had been kept in an alkaline condition.

He thought that along this line of investigation something might be found which would assist in differentiating between the members of this large group of disorders with bullous lesions.

DR. VARNEY said they were indebted to Dr. Lieberthal for presenting such a subject so ably. A dermatologist was usually called in consultation to see a bullous condition and must, often without very much time, give a definite diagnosis. He was sure every one had been mentally refreshed by Dr. Lieberthal's presentation. He did not see many of the pemphigus group, which he did not regret, but in the number he had seen the outcome had been the same as the author's. The dermatitis herpetiformis was much more common and more easily recognized. He was struck with what Dr. Stokes brought out about the neurotic type of patient who presented this condition.

As to treatment, arsenic had been the real standby, although he felt that much had been gained in therapeutics through administraion of autoserum therapy. In a younger patient he found rather prompt response to treatment, but in a patient of advanced age with dermatitis herpetiformis with absolute atrophy of the nails and a condition which had persisted for a long time, the treatment had been rather unsatisfactory as the condition recurred, not always as severe as the original recurrent attacks, but more or less persistent.

Regarding the treatment of pemphigus conditions he had been somewhat in the position of Dr. Lieberthal in not having at his command a medicated bath and he had treated extensive bullous dermatoses with powdered starch, recommended by Charles J. White, and thought he had given the patient much comfort. He practically filled the bed with starch. This treatment had been rather disagreeable when carried out at home because it had been impossible to keep the starch out of the furniture.

DR. MCEWEN was impressed in hearing the paper and discussion with how little was really known about the etiology of skin troubles. Very little in reality was known of the causes of dermatitis herpetiformis and pemphigus and there were many other diseases of which the same might be said, including the commoner sorts such as psoriasis and lichen planus. He thought this fact should act as an incentive to every dermatologist that he should keep up the struggle to discover causes; especially since the discovery of etiologic factors would lead to a more rational therapy. He doubted if there was any branch in medicine in which etiology was as much in the dark as in dermatology.

DR. FREEMAN asked if they had ever found any of their patients who were neurotic previous to the development of the dermatitis herpetiformis, or whether they developed that condition during the course of the disorder. His experience had been that when they had been relieved of the symptoms the neurotic condition was also relieved.

DR. STILLIANS expressed his appreciation of Dr. Lieberthal's plea for the continuous bath. They had tried for a long time to get this accommodation at the County Hospital.

He also agreed with Dr. Freeman that the patients were not so neurotic when they once obtained relief from the itching and sleepless nights. He had a patient who was apparently not at all neurotic when he was free from the distress, and nobody could be blamed for being neurotic in the midst of an attack.

DR. COLE thought the French name for dermatitis herpetiformis was very expressive: "Dermatite polymorphe douloureuse." There was another thing Brocq brought out and that was, that in the lumbar puncture an increased cell count would be found in the spinal fluid. This might be due to the fact that there was some inflammatory reaction of the meninges the same as in the skin. Another thing he mentioned in the etiology and to which he was sure Dr. Corlett would agree as he had had a very large experience with pemphigus foliaceus, some thirteen cases, and that was that his cases had all occurred in Jewish males of Russian origin. The speaker had seen one of these cases and had had one patient since who also fulfilled these requirements. He thought this point was not sufficiently emphasized in most of the textbooks.

DR. ELLIOTT stated that Dr. Foerster saw a case of erythema multiforme with Dr. Wile a few years ago that he was much interested in, particularly as the patient had recently been treated with alkalies. The patient had recurrent attacks of the iris type. Each attack was more severe than the preceding one and they became more frequent. The last two attacks, before alkali was instituted, were accompanied by marked gastro-intestinal symptoms and lesions of the kidney, as was evidenced by large numbers of casts and blood in the urine. Blood was taken and found to be twice as toxic to guinea-pigs as normal blood. Shortly afterward the patient was put on alkali and the eruption cleared up immediately. In the previous attacks it had taken from three to six weeks, but the alkali treatment cleared up the condition at once. They usually gave potassium citrate or sodium bicarbonate.

DR. STOKES said apropos of the neurotic type, he had always distinguished between the man who could not sleep and was nervous from that cause and the man who was the nervous, high tension type of individual, not the man who in the course of an attack was "all-a-tremble" with the strain. The three or four cases on which he based this observation were in the men who were feeling their best between attacks when they had no lesions at all.

DR. SWEITZER asked if any one had tried diet in dermatitis herpetiformis. He became tired of using arsenic and thought it might be well to try diet. He recently had a case in the clinic; most of them had been of a mild type and had not needed hospitalization. In most of the cases they tried a fat free diet and they noticed considerable improvement. The lesions left and the itching stopped to a considerable extent so that they could be sent out to business again.

DR. QUINN said the subject had always been a stumbling block to him; it seemed to him if the patients got well they called the disorder dermatitis herpetiformis and if they died they called it pemphigus. He thought Dr. Lieberthal would remember the case he had shown several years ago which he afterward had under his care at St. Joseph's Hospital. The patient had what was supposed to be dermatitis herpetiformis, but what proved to be a fatal case of pemphigus. In the case spoken of by Dr. Stokes he thought the disorder was probably what Dr. Hyde would have called epidermolysis bullosa. He believed the dermatologists should get to a point where they would not always be describing some little variation in a lesion and put a new name on the disease. Some one had recently said that dermatology was becoming a science of nomenclature and not of real knowledge of skin diseases. They seemed to be making new names and dividing up the same disease. He thought it was at

times impossible to draw the line between Duhring's disease and pemphigus. He thought an attempt should be made to simplify the nomenclature.

DR. ZEISLER stated that he had done quite a little work with autoserum in Duhring's disease and it seemed to have very little beneficial effect, perhaps producing a slight amelioration of the itching. They had recently had a patient who had just received six injections of autoserum from another physician and who had a serious relapse. He had attempted to have patients keep track of their diet in an effort to find out whether there was any particular food which brought on attacks.

DR. AUNER stated that he had had a very limited experience in these cases, but in one case of what in his opinion was a dermatitis herpetiformis he was convinced he secured some effect from autoserum, and when he gave three injections in five days he secured a better effect than in giving a larger number distributed over more time.

DR. EISENSTAEDT said that two or three years ago a young woman came to his clinic with a typical case of Duhring's disease. He took her history rather carefully; she was a girl who was much heavier than normal and was unable to work; her mother supported her. He found that at the age of 24 she had not menstruated more than once or twice a year. He put her on corpus luteum in the hope of getting her menstruation regular. She menstruated regularly in two or three weeks and with this regulation of menstruation the Duhring's disease cleared up. Evidently with the reappearance of her menstruation as a result of the exhibition of corpus luteum there were certain metabolic changes which brought about an improvement.

Another point he wished to emphasize was that the textbooks all stated that pemphigus bullae arose from a normal skin; at least, from a skin which was not inflamed. He had seen one of Dr. Lieberthal's cases before the doctor saw it but did not make a diagnosis of pemphigus. When he saw the patient the lesions were merely vesicles arising distinctly from an erythematous base, but within a week the diagnosis of pemphigus could be made. He believed exactly as Dr. Lieberthal and Dr. Ormsby did, that in many of the cases it was advisable to postpone the diagnosis for a period of time.

DR. HARRIS had been impressed by the fact that there was a whole series of diseases going through the line from urticaria to pemphigus, including lichen planus and possibly dermatitis herpetiformis, in which bullae were found, and he thought they might have some relation to each other. The same cause was apparently present through the whole line and might be due to a metabolic condition. That was brought out by a case that Dr. Zeisler showed some time ago as a possible mycosis fungoides. A month later he showed a patient as a possible dermatitis dysmenorrheica. That case cleared up entirely on a nitrogenous free diet and had remained clear ever since. As to the vegetative lesions, the same thing was probably true; he had never understood just why certain diseases formed vegetating lesions. In certain individuals this tendency was very marked. The same thing was seen in lupus vulgaris in which some of the cases developed vegetations.

DR. LIEBERTHAL, closing, thanked the gentlemen for their discussion. The etiology of pemphigus was so far not known. Yet one was so impressed with the rapidity of the course of some cases that an infectious item might be thought of.

The point raised by Dr. Cole that all of his cases of pemphigus foliaceus had been in the Jewish race, undoubtedly held true for all types of pemphigus. Dr. Lieberthal said that he had seen between thirty and thirty-five cases of the various forms and among these there was only one non-Jewish patient.

Case 4, described in the paper in which the lesions began in the mouth, developed a cutaneous pemphigus and died from it within about two months.

Dr. Quinn's case was interesting indeed. The patient was in the care of a general practitioner over six months. As she showed at the time of the latter's

examination a skin eruption, enlarged glands and a positive Wassermann, he subjected her to very intensive specific treatment, but her condition was growing worse under it. Thereupon she was referred to Dr. Lieberthal. The diagnosis was that of a lichen ruber acuminatus. In the course of one and one-half years under his care she improved considerably, until the last few months when the skin presented large oozing surfaces, with no indication of bullous formation. She then came under Dr. Quinn's care in the St. Joseph Hospital.

Dr. Harris had mentioned a case which previously was in the Michael Reese Hospital. If this should be the same as described by Dr. Lieberthal as Case 2 in the group, herpes gestationis, it would prove further that she suffered neither from pemphigus vegetans, nor impetigo herpetiformis.

The case Dr. Eisenstaedt mentioned was the second in the group of pemphigus. It was that of a woman, aged 24, and it showed how careful one must be in making a diagnosis. She had had lesions in the mouth for three or four months, and erythematous patches on the abdomen and legs, within which were groups of vesicles. The latter were very itchy and the most likely thing to think of was dermatitis herpetiformis, but on account of the lesions in the mouth care in the diagnosis was advisable. Afterward a perfectly typical pemphigus developed.

PARAFFIN PROSTHESIS. Presented by DR. ORMSBY.

The patient was a young woman, aged 36, who had had the disorder for five years. She was first seen in January, 1916, at which time the nodules and tumors had been present for three years and the record showed that the lesions began one year after the injection of paraffin. Surgical procedure was suggested and was followed out in certain areas now shown by scars. Following this roentgen rays were used, without much benefit. Beginning in July, 1916, radium was employed and considerable improvement had occurred under its use.

URTICARIA PIGMENTOSA. Presented by DR. ORMSBY.

The patient, a young woman, aged 30, presented the adult type of urticaria pigmentosa of three years' duration. The eruption had a sudden onset. The original papules were apparently still present and there was no appreciable change in their appearance. On the first examination the patient presented a generalized, evenly distributed, symmetrical, papular eruption. The lesions were most numerous on the forearms. The papules averaged pinhead size. They were slightly elevated and had a yellowish tinge. The palms, dorsal surfaces of the hands and the face were free. The complement fixation test at that time was contradictory, one laboratory reporting positive and one negative. After five months a biopsy was performed, sections of which were presented. There was a complete absence of mast cells. The disorder was accompanied by moderate subjective symptoms.

The second patient was a young woman, aged 21, presenting the same disorder which was present since birth. The lesions were generalized and symmetrical, but sparsely distributed. The typical reaction in this case may be demonstrated. Sections were exhibited under the microscope.

DISCUSSION

DR. SWEITZER recognized the patient as the same one shown last year and thought it was one of the cases of urticaria pigmentosa without mast cells and that it belonged to the class called urticaria with pigmentation, which were slightly different from the cases in childhood. The patient had told him that she had not tried any dietetic treatment and if this was true he thought it would be a good idea to see if some dietary regulation would not prevent the appearance of new lesions.

DR. ORMSBY said that it had only been a short time since adult cases had been shown; he made the statement last year that it would be interesting if a group of adult cases could be shown to have no mast cells. Since then there had been a paper published that showed that there was an adult group with no mast cells, contrary to the findings in the childhood type. He did not believe it was an urticaria with pigmentation. The urticarial lesions were only in response to irritation, they did not itch and they were not an ordinary urticaria. His idea of the urticaria with pigmentation was an ordinary urticaria in which the pigmentation had been caused from irritation.

DERMATITIS REPENS. Presented by DR. ORMSBY.

The patient was a man, aged 27, who presented lesions of six years' duration. The lesion first occurred on the finger, suppurated and spread over the hands. At the time of examination in August, 1917, the lesions were symmetrical, well-defined, crusted and inclined to contain pus. There were also many small white pustules. The nails showed marked dystrophy. A rupioid lesion was present on the forearms. Similar lesions were present on each side of the neck. In spite of all treatment the patient had previously received the disorder persisted. On his arrival here two injections of salvarsan were immediately given; following this the areas were treated with roentgen rays. Since that time various local antiseptics, including aluminum acetate, and Dakin's solution had been employed. Many ointments, including Wilkinson's, a white precipitate, and salicylic acid had also been used and the quartz light had been given a trial, all without result.

DISCUSSION

DR. PARDEE asked if the disorder followed exposure to chemicals.

DR. ORMSBY, replying to Dr. Pardee, said that there was no exposure to chemicals. The lesions began in an infection on the end of the finger which followed an injury.

DR. STOKES said that about a year ago he saw a man who had a psoriasis of the hands of eighteen years' duration. The disorder was confined to the hands with the exception of one small area in the sacral region. The case was very similar in appearance to Dr. Ormsby's but there was no history of an injury. Dr. Ormsby's case was evidently not a psoriasis of the hands, but the sharply defined lesions had for the moment suggested that to him.

DR. COLE stated that he had recently seen a glovelike and shoelike psoriasis and these were practically the only lesions on the body. However, there were no vesicles, no pustules and no history of injury as in this patient. In that case the fingernails looked very much like those in this case.

DR. ORMSBY thought Dr. Stokes evidently did not see the primary lesions in this case, because they were all pustular. When ointment was used it removed all the crusts, and then the primary lesions showed. The pus was very white. He considered the case unusual. The disorder lasted for many years, usually beginning as an infection, and when it became generalized was fatal. He was satisfied that they were not ordinary infections like eczematoid dermatitis; they might be local infections in a susceptible individual. He considered the case an entity and not an ordinary infection.

LUPUS CARCINOMA. Presented by DRS. JOSEPH and ERWIN ZEISLER.

The patient was a man, aged 58, who presented a lupus vulgaris of forty years' duration. It began at the age of 18 on the nose. It was treated with caustics and salves for many years; was treated in London by Dr. Sequeira with the Finsen light in 1913 and 1915 with excellent results. The present trouble started as a nodule in the lupus scar on the cheek nine months ago. It was treated with vaccines and tuberculin for the past six months on the

diagnosis of lupus. The microscopic findings showed a typical squamous-celled carcinoma. The lesion on the cheek was curetted two weeks ago and was being treated with radium and roentgen rays.

CASE FOR DIAGNOSIS. Presented by DR. VARNEY.

The patient was a physician, aged 46. He presented an unusual symmetrical macular eruption. No treatment, other than a bland oil applied after a bath, had been given. He noticed the eruption some two years ago after a warm bath There had been no perceptible scaling and the eruption had caused no constitutional symptoms, except mild itching in the last four months. The case was presented for diagnosis.

DISCUSSION

DR. FOERSTER was of the opinion that it was a case of Brocq's erythrodermia in small patches, the type most frequently seen. He believed there were a great many cases which were not recognized because they were very minor types and as very often there were no subjective symptoms, the lesions were not shown to the physician. The differential diagnosis was of interest in all of these cases because of their resemblance to the premycotic stage of mycosis fungoides.

DR. HARRIS agreed with Dr. Foerster and called attention to the lesion on the back which seemed to be clearing in the center. He thought there was only the one lesion of that character.

DR. SWEITZER believed it was an erythrodermia, particularly after viewing the microscopic section. The man had very little itching and very little scaling and he thought this was probably due to the fact that the patient took better care of the skin than ordinarily taken by such patients.

DR. VARNEY thanked the Society for expressing their opinions regarding his patient. The condition at present was about as when he first saw it four months ago. There was practically no scaling at any time. The plaques which Dr. Harris spoke of on the back impressed him as large for parapsoriasis. For the last four months the patient had complained of some itching, but it had never been sufficiently intense to keep him awake at night.

MULTIPLE BENIGN TUMORLIKE NEW GROWTHS OF SCHWENINGER AND BUZZI. Presented by DR. SENEAR for DR. PUSEY.

This case was reported in detail in THE JOURNAL for September, 1917, pp. 582-588.

ACANTHOSIS NIGRICANS. Presented by DR. ORMSBY.

The patient was a girl, aged 16, who had had the disorder for five years. There were well-marked areas of pigmentation over the sternum and along the mammary folds. The lesions were slightly verrucous and in the axillae were nodules, some exhibiting warty changes. Hyperpigmentation was present also in the genital region.

DISCUSSION

DR. STOKES had the impression that these cases were not so rare as was formerly believed. He thought he had seen one such benign case this year, but he had not called it acanthosis nigricans.

DR. SHAFFNER said he saw the patient about a year ago and at that time there was some pigmentation in the axilla, under the breast and some in the groin. There was no hypertrophy at the time. He considered the case to belong to the polyglandular syndrome because of the (1) obesity, (2) moderate thyroid enlargement, and (3) the pigmentation. He had not considered acanthosis nigricans.

DR. MCEWEN was impressed with the need in this case of differentiating the neck lesions from a pigmentary syphilid. The girl was dark, which made the resemblance more marked.

DR. VARNEY said he had never seen a benign type of this disease, and considered the case very interesting.

DR. ORMSBY stated that they had had the opportunity of seeing only one other case in their own work and, that case being a very marked one, he was glad to have a chance to discuss this one. The other patient was a boy, about 14, with lesions in the same areas as this patient, in the groin, about the perineal region and in the axillary spaces. There was marked pigmentation in these same areas and there were also some lesions in the mouth. The father owned a saloon and the boy drank more than a quart of whisky daily and much beer. He saw him six years afterward and the lesions had cleared up.

He was satisfied that there was a benign type of this disorder which occurred in children and the lesions always got well. The patient presented showed improvement in the lesions.

XANTHOMA PLANUM AND TUBEROSUM. Presented by DR. STILLIANS.

The patient was a Roumanian Jewess, aged 42, and had had xanthoma planum nearly encircling both eyes for the past twelve years. Two years ago she noticed the tumors on the nose. She had a "corset" liver for a long time; had very bad teeth and confessed an addiction to cigarettes. On either side of the bridge of the nose was a hard round nodule about 1.5 cm. in diameter, over which the skin was of normal color or slightly reddened, of normal texture, and movable. A smaller nodule at the left outer canthus was covered by dilated blood vessels. On the right side of the neck was a group of yellowish, flat-topped papules, which were movable with the skin.

DISCUSSION

DR. SWEITZER thought it would be a good plan to cut off the lesions, as they could be removed in that way better than any other.

DR. ORMSBY considered the case a typical xanthoma tuberosum, which was a tumor formation. He thought they all recognized the fact that the xanthoma planum was a degeneration process, and wished to know if the recurrence which happened when the lesion was excised was a recurrence in the same place. He thought it was rather hard to account for the degeneration of the muscle when the lesion had been removed.

DR. STILLIANS had found the case interesting because of the fact that the two conditions occurred together. He had never been able to convince himself that they were entirely different diseases. He had used radium without much effect.

DR. STOKES was interested in the possible influence of trauma on the development of the lesion in these cases of xanthoma for the reason that in a recent legal action in an accident case, he had great difficulty in evading an opinion on it. In that case there was a typical xanthoma lesion following trauma to the hand. He recalled the work of Anitchkow on experimental xanthoma and wondered if there were any similar experiences in cases of this sort in man.

SYPHILIS, ERYTHEMA INDURATUM AND LICHEN PLANUS. Presented by DR. STILLIANS.

The patient was a Polish woman, aged 33, who had had the nodules on the anterior surface of the wrists for several years. She was infected with syphilis three years ago and a year ago had a gumma of the palate, leaving a large perforation which was now closed by a hard rubber obturator. While taking potassium iodid for syphilis she developed the hard, brown indurations

on the backs of the legs. The one on the left leg had been treated recently by the quartz lamp. Her Wassermann reaction had been negative for about a year. She was on treatment at the time of presentation.

At the time of presentation she presented a dark red, hard nodule about 1 cm. in diameter and 0.3 cm. high, on the anterior surface of either wrist. They were somewhat hyperkeratotic and scaly at the top. On the backs of both legs, in the lower half, were large reddish brown indurated areas, not raised above the skin surface, irregularly shaped, from 5 to 8 cm. in diameter. In the center of one of these a rather sharply defined ulcer 1.5 cm. in diameter and about 0.5 cm. deep was seen. The other lesion was not ulcerated.

DISCUSSION

DR. MCEWEN asked why Dr. Stillians felt the need of the diagnosis of erythema induratum; could not the nodules be syphilitic?

DR. VARNEY asked whether the erythema induratum had shown any improvement under syphilitic treatment.

DR. STILLIANS stated that the hard, dark brown plaques occurred under antisyphilitic treatment and had persisted in spite of all the treatment she had had, and thought since the large induration only occasionally broke down it gave him a good deal of justification for the diagnosis of erythema induratum. She had recently had a rather sharply defined lesion which looked like a gumma, which healed up afterward, but the induration did not heal. He thought it might have been a gumma in an indurated area. He had never seen a gumma with so much pigmentation and induration that persisted so long.

CASE FOR DIAGNOSIS. Presented by DR. MCEWEN.

The patient was a man, aged 47, who presented a lesion situated on the nose which began six or seven years ago as a soft raised papule about the size of a large split-pea; a scale continuously formed. The increase in size was slow. Two years ago the lesion was excised. A recurrence followed. Eight months ago it disappeared under roentgen-ray treatment and had since recurred. The lesion consisted of a number of papules in an oval distribution within an area which was reddened, somewhat thickened and showed many telangiectases. The papules were soft and seemed fluctuating, but their content was not fluid. There were practically no subjective sensations. The patient had never been seriously ill, but was not rugged in health. There was no history of tuberculosis or of syphilis.

DISCUSSION

DR. HARRIS thought the case was a basal cell epithelioma which probably contained some cysts, although it was possible to get such an appearance without cysts.

DRS. SWEITZER and ORMSBY agreed with Dr. Harris.

DR. LIEBERTHAL asked if the process had been spreading.

DR. MCEWEN stated that the disorder, according to the patient, began as a flat lesion which evidently had a scale. For a long time it was quiescent and some one advised him to have it removed; it was excised and then there was a recurrence. It had once been removed with roentgen rays, with recurrence which was much the same as before the roentgen-ray treatment was used. It began in the form of very small, reddish-yellow, soft papular units which were soft from the very start. They did not appear as hard nodules which were undergoing softening. His diagnosis agreed with that of Dr. Harris, but he had considered whether it could be an example of colloid milium.

MYCOSIS OF THE SCROTUM. Presented by DR. SHAFFNER.

The patient was a man, aged 22, who presented what appeared to be a new dermatosis, which was prevalent in the House of Correction. It always involved the scrotum and sometimes the penis where it came in contact with the affected scrotum. It never involved the groin as in tinea cruris. The disease had become endemic and seemed to be more prevalent in those working in the tailor shop. Itching was intense and the condition was very refractive to treatment. Scrapings had been negative for anything definite in the way of a mould and the cultures had yielded in many instances yeast cells all of the same type and in most instances in pure culture. Skin sections were negative for parasites. Several of the patients had said that on leaving the institution and wearing their own underwear the disease had spontaneously disappeared. Photographs and microscopic sections of several of the other cases were shown.

DISCUSSION

DR. FREEMAN thought that in the photographs which were shown there was an appearance of an eczema marginatum and wondered if the other patients had the same appearance. In the patient shown this was not present.

DR. HARRIS called attention to the fact that the disorder might be due to the mechanical irritation of the clothes. The raphé was depressed beneath the rest of the scrotum and was not affected. He had examined the section and it showed a very marked hyperkeratosis and some parakeratosis.

DR. SHAFFNER said he first saw the patient last May at the House of Correction and he was astonished to see how many cases were present there and how many had developed since. On first examination he thought it was an example of fungus disease, but so far he had not been able to find anything definite. He had grown a lot of yeast cells and that was all. There had been many cases of eczema marginatum and in those he had no difficulty in growing the epidermophyton inguinale. The men were certain that if they wore their own underwear the eruption would disappear spontaneously. They thought it might mean that there was something used in the laundry that was the causative factor or perhaps was of such a nature chemically as to permit the growth of a parasite if such was the etiologic factor.

CHANCRE OF LOWER EYELID. Presented by DR. SHAFFNER.

The patient was a woman, aged 38, with a lesion of four weeks' duration situated on the lower left eyelid. A nodule, markedly indurated, exhibiting a small ulceration was present. In addition a very large submental lymph gland could be palpated.

DISCUSSION

DR. FOERSTER considered it a chancre and understood the inoculation to have originated in the removal of a foreign body. He had seen a chancre under the external canthus which followed the removal of a foreign body by a physician.

DR. SHAFFNER said the case was simple and of only four weeks' duration. There had been no difficulty in finding the spirochete. The interesting feature was that the woman said her daughter had a very sore throat, and the daughter volunteered the information that she thought she infected her mother by removing a foreign body with her tongue. The daughter (also shown) presented a typical syphilitic angina, generalized lymphadenopathy and a fading papular eruption.

BLASTOMYCOSIS. Presented by DR. ORMSBY.

The patient was a man, aged 41, who presented a blastomycosis of fourteen years' duration. The first lesion occurred on the right thigh, near the scrotum

and appeared to be a red "pimple." This ulcerated and spread. The patient was treated for some years with potassium iodid and roentgen rays without much effect on the disorder.

He was first seen here in July, 1916. Treatment was followed out under the direction of his local physician for a year without improvement. In October, 1917, the patient returned, having evidences of a general infection. At that time he was practically bedridden. From then until the present he had had nine injections of salvarsan, with great improvement.

DISCUSSION

DR. HARRIS remembered the case from the previous meetings and thought the patient showed marvelous improvement under treatment.

DR. ORMSBY said the patient had had what appeared to be a hopeless blastomycosis, which was generalized.

SYRINGOMA. Presented by DR. SHAFFNER.

The patient was a man, aged 21, who presented lesions on the chest which had been present since early childhood. The lesions consisted of numerous pink, solid elevations of the skin, with no inflammatory characteristics, varying in size from a pinhead to a pea. The tumors were situated entirely on the anterior aspect of the chest, extending from the clavicle to the epigastrium. There were no subjective sensations.

Microscopic section showed a typical syringoma.

DISCUSSION

DR. MCEWEN thought it was a syringocystoma, similar to a case Dr. Ormsby had presented several years ago.

DR. HARRIS stated that he had shown a patient with practically the same clinical picture in whom all the lesions had disappeared under roentgenotherapy, leaving no atrophy or any change in the skin.

DR. SWEITZER wondered what would be the best method of removing the lesions and thought it might be possible to use a cauterization outfit and remove them with very little scarring in that way. He believed the area was too large to be treated with roentgen rays.

DR. FOERSTER thought the case was similar to one shown by Dr. Ormsby several years ago which had cleared up under roentgenotherapy, and wished to know if the result obtained was permanent.

DR. ORMSBY considered his case interesting on account of the fact that the lesions were generalized and much larger than these. His patient had lesions on the face, including the lips, and while she had the lesions she did not perspire at all. After she recovered the function of perspiration was restored. It took four or five treatments as given at that time to remove any individual areas. She was treated all over and there had been no recurrrence. She had been well for about ten years.

DR. SHAFFNER stated that the section which had been so much complimented was the work of Dr. Harris.

STERNBERG'S TUBERCULOSIS. Presented by DR. HARRIS.

The patient was a man. The lesions consisted of papulo-necrotic tuberculids with zoniform distribution. (The case had recently been shown at two previous meetings.)

DISCUSSION

DR. COLE considered the case very interesting and thought he would not have been able to make a clinical diagnosis. He thought this would not have been possible until there had been a study of the glands and of the blood, and

an opportunity to observe the case for some time. He believed these cases and the leukemias were very closely related. He had recently had a case of typical sarcoma of Kaposi with a lymphatic leukemia, and a white cell count of 150,000. He thought it was a question whether they were not all closely connected and an infection of the same type. He did not as yet agree with Bunting and Yates that it was a diphtheroid infection.

DR. HARRIS stated that the patient was very much better than when he was shown before and believed this was due to roentgenotherapy. A gland was removed and revealed the typical picture of caseous tuberculosis. Lesions were taken out in the zoniform area and showed tuberculosis of the skin. The question was whether it was a tuberculosis or a tuberculid. He had not been able to demonstrate the organism in the section.

CASE OF SCALY SCALP. Presented by DR. HARRIS.

The patient was a man, who presented scaly patches of the scalp which had been present for six years and were very resistant to treatment. The case had been shown at the annual meeting for several years. The extent of involvement varying from time to time, but always showing the closely adherent scaly patches in the scalp, which reacted to no form of treatment. Temporary improvement was obtained by the use of almost any irritating application.

DISCUSSION

DR. VARNEY considered the case interesting because Dr. Harris said he had tried everything in the way of treatment, without result. The infiltration of the lesions impressed him as a point of interest and deep for psoriatic lesions. The lesion had a clean cut margin and psoriatic scaling, and he thought it to be a psoriatic patch.

DR. FREEMAN thought it might be a lupus erythematosus or a psoriasis. The little patch on the ear was like lupus erythematosus, and he believed the entire eruption was more like a lupus erythematosus than psoriasis.

DR. HARRIS said he showed the case in an attempt to get some idea of treatment. The condition would clear up but immediately return. The scales were very adherent. The man had the same scaly condition of the scrotum. It was not a psoriasis. Some of the lesions disappeared spontaneously but they recurred. It was not a lupus erythematosus. There was no alopecia and no atrophy in any of the lesions, either after they disappeared spontaneously or after they were removed by treatment. Occasionally there was a very little itching.

SPOROTRICHOSIS. Presented by DR. HARRIS.

The patient was a bridge builder from Iowa, who had had the disease for about a year. He showed the typical lymphatic distribution of sporotrichosis involving the arm and leg.

DISCUSSION

DR. ZEISLER thought the lesions might be called sporotrichial gummas.

DR. MCEWEN said he had noticed the atrophy of the muscles of the hand and wished to know the cause of it.

DR. HARRIS said that in the absence of Dr. Pusey he wished to register his objection to the term "sporotrichotic chancre" and "sporotrichotic gummata." The lesions were not gummas, to be sure they were nodular and underwent the degeneration the same as was the case in gummas, but they were not gummas. The atrophy of the muscles of the hand was probably due to an operation in the axilla.

MORPHEA GUTTATA. Presented by DR. ORMSBY.

The patient was a girl, aged 9, who had had the disorder for two months. The lesions occupied the original site, but showed improvement under treatment with roentgen rays. (Photographs were exhibited.)

DISCUSSION

DR. VARNEY thought the condition was a very interesting one and typical of morphea guttata.

DR. COLE asked what treatment Dr. Ormsby was using.

DR. SWEITZER asked if a section had been made to establish the diagnosis. The case reminded him of a lichen planus sclerosus.

DR. ORMSBY said as to the differential diagnosis, in the cases of lichen planus sclerosus there were always more papules and comedonelike plaques which were black. If they were not there, there was the opening where they had been and in this case this condition was not present. The lesion was more white. He had done a lot of work on those two types of lesions and helped confuse the matter a few years ago. There were two diseases, one the morphea guttata which this case was, and the other the lichen planus of Hallopeau. There was no such disease as "white spot" disease. There had been no histologic study of this case.

ACNITIS. Presented by DR. QUINN.

The patient was a man, aged 25, by occupation a street car conductor, who presented lesions of two and a half months' duration. The onset was rapid, following a chilling of the face. The lesions had remained about the same since the first few days. The Wassermann reaction was negative, and venereal infection was denied.

Microscopic examination revealed *Staphylococcus pyogenes, albus* and *aureus*. The lesions were confined to the face and ranged in size from a pinhead to a split pea.

DISCUSSION

DR. FOERSTER thought it was an acnitis with a tuberculosis. If the lesions were small they were called lupus. He believed all of the lesions were caused by the tubercle bacillus.

DR. QUINN thought he had never seen an acnitis which looked exactly like this, but believed that was the diagnosis.

DR. ORMSBY thought the picture of the disorder was so typical of the acnitis cases on record that it looked as if it had been taken from them. The lesions were all the same, the grouping was in the same areas, and all the cases he had studied were exactly like it. As to the tuberculous side of it he stated that with the most careful work that had been done there had been no successful inoculation from the tissue and the tubercle bacillus had never been found.

CASE FOR DIAGNOSIS. Presented by DR. QUINN.

The patient was a man, aged 26, an Austrian, married, who presented a disorder of seven years' duration, which consisted of atrophic scarring of the forearms and lower extremities. Wassermann reaction and urinalysis were negative. The patient complained of burning of the skin which was present almost continuously. There was an urticarial reaction on various parts of the body. He denied that the scarring was due to a burn or that it was present previous to three years ago, and said that it was gradually extending.

DISCUSSION

DR. QUINN stated that the man had had the condition for seven years and the question was brought up as to whether the scarring was not the result of a burn. He had been under treatment principally by neurologists but did not seem to improve. The scarring was present on both arms, more marked on one. At times there were some lesions which resembled urticaria which were temporary. The man was a hypochondriac, but he wished to know what was causing the scars.

DR. COLE thought the fact that the area was shiny and more or less symmetrical might indicate a possible dermatitis chronica atrophicans.

DR. MCEWEN did not believe the scarring was taking place from anything that was happening at present. He had looked closely at the right hand and arm and there was no condition of scarring present. On the left arm the scarring was higher up on the arm than the active lesion, and he believed it was the result of a burn in early life. The man was a neurotic and was probably "enjoying poor health." He had probably learned that he was more interesting as a patient if he denied being burned.

DR. FREEMAN agreed with Dr. McEwen, and said he knew of no skin condition of that nature that had not been preceded by other changes.

CARCINOMA ON ROENTGEN-RAY SCAR. Presented by DR. MCEWEN.

The patient was a colored woman, aged 49. Six or seven years ago a lump appeared in the breast, which was diagnosed as carcinoma and removed. Later the growth recurred and the patient was again operated on two years ago. Following the first operation she received ninety-one roentgen-ray treatments of thirty minutes' duration every second day. At present there was a palm-sized plaque of induration, seated on an atrophic area of several times that size; this area of scarring was sprinkled with telangiectases and was obviously due to roentgen-ray exposures. The case was submitted for suggestions as to treatment—whether by excision, or by roentgenotherapy.

DISCUSSION

DR. ORMSBY stated that he saw a case about six months ago of a very extensive roentgen-ray burn in which there were ulcerated lesions over the chest. He had suggested that they use hot saline applications, which had been urged by Dr. Foerster. The patient could not stand that form of treatment and the doctor used Dakin's solution and the entire area healed up. It was the best result he had ever seen in a chronic roentgen-ray burn.

DR. MCEWEN said the impression seemed to be that the case was presented on account of the roentgen-ray burns. He called the attention of the members to the fact that it was distinctly a carcinomatous condition and the question was as to treatment—whether there should be further operation or more roentgen ray.

DR. LIEBERTHAL stated that in cases of roentgen-ray burn he had often seen wonderful relief from the quartz lamp and suggested that it be tried, using the white light with short exposure and a distance of about 6 inches.

DR. ORMSBY said in many cases a single exposure to radium entirely cleared up the keratoses in four weeks. All the cases in which this treatment had been used were physicians who had followed instructions exactly, and the result was all that could be wished for. When using a one-fourth strength applicator which contained 5 mg. and covered a surface of a little less than 1 inch, it was kept on the area for eight hours and filtered through a silver filter.

DR. LIEBERTHAL believed more roentgen-ray applications would aggravate the condition.

DERMATITIS. Presented by DR. STILLIANS.

The patient was a girl, aged 18. She had suffered with a dermatitis for over a year, which appeared first on the chest. This promptly cleared up on treatment with vaccine. Since that time it had recurred in various areas, especially around the genitalia, at irregular intervals without any apparent cause. At the time of presentation it was present in the axillae, crural region and feet. When first seen it involved the axillary regions, the arms and groins.

The eruption had been extremely refractory to treatment. It consisted of rather sharply defined areas of lichenification in the axillae and groins of dark brownish-red, with small papules along the border, in places. The lesion on the dorsum of the left foot was weeping.

DISCUSSION

DR. FREEMAN asked if there was a vaccine therapy in this case.

DR. VARNEY stated that he had found the *Staphylococcus pyogenes aureus* more often than the *Streptococcus pyogenes*. As for vaccine administration he had obtained better results with the polyvalent stock suspension embodying strains from similar pyogenic dermatoses than with the autogenous suspension. The stock suspension produced better therapeutic results. If there was no evidence of infiltration in the inoculated area within forty-eight hours, a second inoculation was made. There should be a definite time to repeat the inoculation, the initial inoculation beginning with 75,000,000 to 100,000,000, repeating the inoculation in five times twenty-four hours, not five days, and increasing the dosage in each inoculation so as to bring about immunization in each individual case. This immunization was not only shown by clinical improvement, but by Arthus' phenomena.

BLASTOMYCOSIS. Presented by DR. HARRIS.

The patient was a negro, aged 24, who had had the disease for sixteen years. It commenced as a small pustule on the penis and spread to the pelvic region and since had involved the lower abdomen, buttocks and thighs. The central part of this large area was scar tissue but around the periphery was seen the characteristic lesions, from which the organisms were cultured.

CASE FOR DIAGNOSIS. Presented by DR. STILLIANS.

The patient was a woman, aged 30, who entered the hospital with a suspicion of trichinosis; three of her children were in the hospital with this disease. In addition to the probable trichinosis, lesions were discovered on the chest and back, one of which had been present for twenty years. There was also a lesion on the left arm. The lesions on the breast had been present for about four years.

The lesions consisted of two frank keloids in scars on the left shoulder and right breast. In addition to these, a number of flat-topped, round nodules were present, one of which, in the epigastrium, was dark brown in color. The others were dull red and not shiny, not tender, but movable with the skin. The scalp was covered with thick, yellowish scales.

DISCUSSION

DR. HARRIS stated that the woman had had a tumor removed from the right shoulder eight years ago; some time later lesions appeared on the chest. Some parts of the scar looked like a keloid; the tumors had varied in size from a split pea to a button. They were brownish-red or blue, and the question was whether they were spontaneous keloids.

DR. SHAFFNER thought the lesions were keloids.

DR. SWEITZER thought they might be sarcomas. Dr. Harris could tell definitely after examining the section which had been removed on the previous day.

DR. FREEMAN believed the fact that one lesion appeared in an old vaccination scar would not rule out a keloid. The ones on the breast did not look the same as the ones on the left arm and shoulder.

DR. QUINN thought they were keloids.

DR. COLE thought it was a possible sarcoid.

DR. HARRIS stated that the woman had had about eight lesions on the breast, all of which showed the same picture. He thought it was probably a case of spontaneous keloid, although it was rather peculiar. In one place there was an infiltration of new growth in an old scar. He would like to make a biopsy.

TUBERCULOSIS OF THE NOSE. Presented by DR. HARRIS.

The patient was a man, a Syrian, aged 37, with a tuberculous lesion which had entirely destroyed the septum. The disease started five years ago, shortly after reaching this country. When he entered the hospital the under surface of the tip of the nose and the adjacent part of the upper lip was the seat of a verrucous growth of a rather soft consistency. The bony and cartilaginous septum had been entirely destroyed so that the tip of the nose could be lifted up. Biopsy revealed the typical tuberculous changes and the disease reacted to roentgen-ray therapy. The organisms were cultured.

DISCUSSION

DR. QUINN stated that as the microscope had shown it to be tuberculosis, it must be so, but it looked to him like a late syphilitic infection.

DR. HARRIS said the patient came into the hospital with what looked like a verrucose tuberculosis with a history of the disease having come on within a few months after reaching this country. He made a diagnosis of tuberculosis cutis and biopsy had proved it to be the case. The patient was clinically well under roentgen-ray treatment and was transferred to the nose and throat department for treatment of the nasal mucosa. Since then he had more roentgen-ray therapy, and was now much worse than when he was transferred.

LUPUS ERYTHEMATOSUS. Presented by DR. MCEWEN.

The patient was a man, aged 37, who presented lesions of long standing, which involved the face and hands. Those on the face had been present eight years; those on the hands less than two years. The lesions were typical and the diagnosis unquestioned. The case was submitted for discussion of probable prognosis.

DISCUSSION

DR. MCEWEN said that the lesion on the face had been present for about eight years, but some of the lesions were much more recent. The diagnosis was lupus erythematosus but the patient was shown on account of the hand lesions with the object of having the prognosis discussed. He cited the case of a woman who had come to the hospital with lupus erythematosus on the face and hands. Under hospital care she improved greatly, went out and returned after a few days with a marked exacerbation and within a month died of tuberculosis. He had in mind the possibility that this man might be beginning to show dangerous systemic extension. He thought he showed more lesions now than when he came into the hospital ten days ago.

DR. FREEMAN thought the case was interesting from the point of localization.

DR. ORMSBY stated that he had just had the same experience with a case. A patient they had for several years had lesions on the face and a few on the arms, then developed an acute attack and at that time looked like a patient with multiple erythema. She was covered all over with lesions. He believed that as the hands were affected the prognosis should be guarded. If a general attack resulted it would probably be serious.

TUBERCULOSIS OF SOFT PALATE IN A SYPHILITIC. Presented by DR. STILLIANS.

The patient was a man, aged 23, who had syphilis of one year's duration. The soft palate showed groups of pinhead-sized ulcers, from which tubercle bacilli had been obtained.

DISCUSSION

DR. ORMSBY thought the case was important because every once in a while they had to pass on such cases. He had seen one such patient recently, and in the last two or three years he had observed several. The lesions involved the mucous membrane of the throat and mouth. He saw a case, two or three years ago, in which the lesions were largely of the throat and the nose and the throat specialist who had examined the patient had made a diagnosis of tuberculosis. The Wassermann test was strongly positive. For three months he was given antisyphilitic treatment; then the tubercle bacillus was demonstrated. On the previous day he had seen a patient with a tuberculous throat and tongue. Two or three of the cases seen in the last few years had cleared up under treatment with radium or roentgen rays. The results with this therapy had been very good when the lesions were limited.

DR. HARRIS stated that the tubercle organism had been found in the lesions. It was interesting to note how easily these organisms were found in mucous membrane lesions and how difficult it was to find them in lesions of the skin. He had seen miliary tuberculosis develop, following administration of potassium iodid.

DR. MCEWEN asked what effect there had been on the lung lesion from the administration of salvarsan.

DR. COLE stated that he gave a man with an old latent tuberculosis a few treatments with salvarsan, first 0.3 gm., then 0.4 gm., and then 0.5 gm., and about three weeks after the last treatment he became ill and later died of miliary tuberculosis. He had no potassium iodid.

DR. FOERSTER said he had had an unfortunate experience recently with acute miliary tuberculosis, developing after salvarsan, in a recent syphilitic with pulmonary tuberculosis which condition was supposed to have been cured. In a case of tuberculosis of the knee joint, the young woman being confined to bed with the joint in a cast, a laryngologist was consulted for some throat trouble, shortly afterward a chancre of the tonsil developed and was not recognized until the patient developed very marked secondaries. She was given 0.2 gm. and 0.3 gm. of old salvarsan; her knee joint began to flare up, she grew stuporous, and died of tuberculous meningitis about four weeks later.

DR. STOKES stated that on Dr. Wile's service he had had an interesting experience in the case of a nurse with pulmonary tuberculosis with bacilli in the sputum and a positive Wassermann reaction. When under salvarsan she gained weight and at the end of her course of treatment was remarkably improved. He believed that the majority of unfavorable effects from salvarsan had occurred in febrile and rapidly progressing cases. It was his practice to give salvarsan intensively in glandular tuberculosis with associated papulonecrotic tuberculids and he had yet to see anything but good effects from the treatment.

NODULAR SYPHILIS. Presented by DR. MCEWEN.

The patient was a man, aged 46, who presented contracted scars over the left side and back. The patient was distinctly syphilitic and showed a few active lesions of the tertiary type. He was presented because of the unusual extent and hypertrophy of the scars.

Necrologic

ALFRED FOURNIER, 1832-1914

By J. Darier, Médecin de l'Hôpital Saint Louis

PARIS

Translated with the author's permission, by John E. Lane, M.D., New Haven, Conn. (Published in French in *Annales de dermatologie et de syphilographie*, 5, p. 513.)

In Paris, Dec. 25, 1914, the acknowledged leader of syphilography in France and in the world, the indefatigable and productive worker, the affable and sympathetic man, Professor Fournier, died.

The din of battles raging throughout the whole of Europe, the countless sorrows and the patriotic duty which kept every man fit for military service with the colors, scarcely permitted the colleagues and the pupils of the teacher, the friends of the physician and those indebted to him, to properly estimate the extent of the loss which they had just sustained; most of them were unable to testify their attachment to him and to show their sorrow by taking part in his obsequies. It was a cortege of modest number, which, without pomp and without funeral oration, accompanied to his last resting place the man whose name and whose teachings no syphilographer, no educated physician, for nearly half a century, has been able to ignore.

The time has come for sketching the history of his life, so beautiful and so full of usefulness, for summarizing the acquisitions which science owes to him and for offering to his memory a tribute of admiration, of respect and of gratitude. But alas, to be able to render unto him who was my teacher the homage which is his due—I should need to possess his talent.

HIS LIFE WORK

Fournier's career is a rare example of perseverance in one single course, of struggle and effort toward a single goal. To the zealous and tenacious strife which in his early manhood he commenced against one of the worst plagues which afflict humanity, he consecrated the whole of his strength and of his time. Endowed with fineness and clearness of intellect, with a logical mind, with patience in clinical observation and in the accumulation of evidence, with elegance of style and of speech, he employed all these qualities in the service of this apostolate. For Fournier was really an apostle, and when he attacked this "modern plague," this "social menace," syphilis, he felt that he was fulfilling—not a simple duty—but a veritable mission.

His entire work, too, revolves in a definite orbit: those of his studies which deviate from it, although marked with the masterful qualities of their author, give the general impression of being accessory and unessential; then too, they not infrequently converge toward the chief object of his preoccupation by a little frequented path.

It is interesting to try to find the way in which his thoughts and his activity became oriented in this direction; and indeed, the story of his life and some traits of his character easily supply the explanation.

EARLY YEARS AND STUDENT LIFE

Jean Alfred Fournier was born in Paris on May 12, 1832, of a Parisian family which, as far as I know, had no physicians among its members.

Entered in the Institution Jauffret, of which he always retained the most grateful recollection, he there studied the classics with great success; it was there that he obtained his marked taste for the humanities, especially for the Greek and Latin authors, whom he translated at sight and from whom he delighted to quote long passages which had remained in his memory.

In 1855, he was appointed Interne des Hôpitaux, and was assigned to Ricord's service at the Hôpital du Midi. This entirely accidental circumstance must have had a decisive influence on his career. He very soon became the favorite pupil of this excellent and witty teacher, whose luminous teaching and attractive personality had immediately charmed him. He found himself initiated into, and also soon taking part in the heated discussions which at this time agitated the clan of students of the venereal diseases.

These impressions of his early career could not have been effaced by his transference as an intern to the service of Chassaignac, of Germain de See, of Bergeron, of Boucher de Villejouy and of Ricord. His doctoral thesis on "Syphilitic Contagion" (1860) clearly demonstrates it.

Next came the period of competitive examinations which, thanks to his ability and industry, did not delay him long. The same year, 1863, sees him at the age of 32, Médecin des Hôpitaux and Professeur agrégé de la Faculté.

APPOINTMENT AS A TEACHER

From this time his career is clearly marked out and will develop harmoniously. Supplying in place of Professor Grisolle in 1866 and 1867, he begins teaching in the clinical chair of the Hôtel-Dieu. Appointed chief of service in 1868 at the Hôpital de Lourcine, where he was to spend eight years, he begins his unofficial course of lectures on syphilis. This course was, in 1871, officially designated Cours complémentaire de la faculté, and was transferred to the Hôpital Saint Louis in 1876.

By his appointment to the chair of "Clinical Professor of Cutaneous and Syphilitic Diseases" (1880), of which he was the first incumbent, as well as by his election to the Academie de Médecine (1879), he had attained the highest ranks of the medical hierarchy.

The success of his teaching and the reputation of his academic lectures are well known. His presidency of the Société française de dermatologie, his promotion to various ranks in the Légion d'Honneur, of which he was commander, were also the cause of an entirely legitimate satisfaction to him.

It would be impossible for me to name the innumerable learned societies, both French and foreign, of which he was a member, and the numerous official commissions of which he was the life. It will suffice to recall how dear to his heart was the "Society of Sanitary and Moral Prophylaxis," of which he was the founder and president. Neither must I forget in this place the zeal which he showed in doing his share of the editing of our "Annals" (i. e., *Annales de dermatologie*), and the constant care which he took to maintain the proper proportions of syphilography and of dermatology in its columns.

FAMILY LIFE

So, loaded with titles, with honors and with activities, having universal renown and public esteem, completely happy in his family life, delighting to surround himself with friends and devoted pupils in his home, which was harmonious and adorned with many beautiful objects, he was able to watch the approach of old age with serenity.

But what man can be called happy before his death? His last years were darkened by the long and cruel sickness of her who had been the companion and the charm of his life; infirmities came to him, bringing him the anguish of feeling his robust health and his noble intellect gradually fading away. His faculties were dimmed and he died peacefully, without a full realization of the tragic events which were going on around him, and he had no share in the stifling emotions which held his country in their grip. He had finished his task, and now I wish to show how greatly he honored his country by his work and by his character.

CONTRIBUTIONS TO LITERATURE

Fournier's first publication was "Lectures on the Chancre" of his teacher Ricord (1867), lectures which he edited and amplified with many notes and much personal research. This book maintains the duality of the virus of chancre, and supports the theory on the clinical differences and on the results of the auto-inoculation of the two varieties of chancre. Two years later the editor of these lectures will show that the instructive method of "confrontation" due to Bassereau, formally establishes this theory.

In the meantime he takes up some related problems which need solution. In considering the "Cephalic Chancre" (1858) he demonstrates that the extreme rarity of the soft chancre on the face is not due to a transformation of virus, but to a relative immunity of this special terrain to one variety of chancre.

In his doctoral thesis on "Syphilitic Contagion" (1860) he asserts that the suppurative form of secondary eruption is contagious and that it produces a hard chancre. In another paper he studies the incubation of syphilis, especially cases of long incubation.

In rereading these works of his youth, which date from the time of his internship, it is surprising to find the methodical and clear mind, the bent of mind and even the style, which characterize the man in his maturity. He is not content with vague formulas. He wants the naked truth. This truth does not interest him simply for its own sake as a conquest of the unknown, for the self satisfaction of the investigator, but on account of the practical results which will be gradually derived from it. Questions of scientific theory assuredly do not leave him indifferent, but we feel, even at this early period, that the chief object in view is social hygiene, that is, prophylaxis.

However much less important, in comparison with his work on syphilis, his writings on general medicine and on dermatology may be, they, nevertheless, do not deserve to be forgotten.

His thesis of agrégation on "Uremia" is a critical review of a subject chosen by the examiners, of which little was then known. In the thesis is found not only what was known about the subject, but also a clear opinion of the direction in which research might be pursued.

His article on "Alcoholism" in the Dictionnaire de Médecine et de Chirurgie Pratique (1864) is clearly stamped with his didactic talent. Moreover it is noticeable that in this matter also he sees safety in prophylaxis.

DERMATOLOGICAL WRITINGS

As to his articles on dermatology, most of them are the reproduction of clinical lectures on well known subjects such as herpes, urticaria, hydroa buccalis, etc., but the subjects are presented in a very personal manner. There are other monographs on new subjects; there is a very detailed study of the eruptions on the genitals which are seen in diabetics, for which he coined the name "diabetides"; the description of an acute eruption which he calls "herpes vacciniformis of young children" and which is of interest because of its frequently syphiloid appearance; several notes on the "eruptions" due to antipyrin," of which he was the first to point out three special forms, the pseudo-

syphilid of the palm, the antipyrin roseola and black penis. His name will also be associated with the question of "fulminating spontaneous gangrene of the penis" and with the first description of "recurrent buccal herpes in syphilitics."

It will be noticed, and it is entirely natural, that the dermatological types which particularly attracted Fournier's attention are those which have some points of contact with syphilis. Neither is it at all surprising that he should have been interested in mercurialism and iodism.

At the time when he was supplying for Grisolle, circumstances led him to busy himself with "Gonorrhea and Its Complications." He wrote an article on this subject for the Dictionnaire de Jaccoud, and the celebrated discussion on gonorrheal rheumatism (1866) at the *Société Médicale des Hôpitaux* made it the topic of the day. In his article he has not completely freed himself from the theory of his teacher Ricord: While he declares that blennorrhagia is a special inflammation, different from simple urethritis, he does not admit the existence of a specific virus and accepts the theory that an individual may transmit blennorrhagia without having it himself. As for gonorrheal rheumatism, he rejects the idea of its being a mere coincidence or the awakening of a diathesis, and supports the theory of "urethral rheumatism."

Moreover, it must be recognized that before the advent of bacteriology, it was almost impossible to solve this problem by clinical resources only; that the description he gave of gonorrheal rheumatism is remarkable, and truly that of a master hand; that besides he was the first to assert (1868) the existence of a "gonorrheal sciatica," often coexisting and sometimes alternating with the articular manifestations. It is to him also, that is due the recognition of the "nodular, deforming and amyotrophic form" of gonorrheal rheumatism; he reverted to this subject in 1889, showing that this complication, though rare indeed, is one of the most terrible results which may ensue to darken the prognosis of this disease. Finally it was he who sketched, and later completed in 1885 and 1886, the first description of "spontaneous or metastatic blennorrhagic conjunctivitis," which is not the result of pus being carried to the eye, but which is habitually coincident with the rheumatic manifestations. This special form of conjunctivitis is of little gravity, evanescent and easily undergoes resolution, and his interest in it was that it may serve as tell-tale evidence in advance of any confession or local examination.

A TEACHER OF SYPHILOLOGY

As soon as he became physician of Lourcine, Fournier began the methodical teaching of syphilology in which he excelled. His lectures, prepared with extreme care, were intended for publication. In 1873 the first edition of his "Lectures on Syphilis, Especially Syphilis in Women" appeared.

In scrutinizing the rich clinical material which passed before his eyes, the author had noticed some curious and little known accidents which are sometimes produced during the first stages of the disease. He published special articles on "primary induration," the "indurated pseudo-chancre," the "tendinous synovites," "analgesia of secondary syphilis," "secondary adenopathy," etc. All that, in addition to many other things, is found in his "Lectures on Syphilis."

The striking thing in this volume, which is devoted to the primary and secondary stages only, is that in addition to admirably precise descriptions of indisputable syphilids, the author devotes considerable space to the general condition, and to visceral and functional accidents; he lingers long not only on the painful manifestations, but on analgesia, paralysis, algidity, hyperidrosis, on syphilitic fever and typhoid, on palpitation, anorexia, bulimia, emaciation and cachexia, which, he declares, are commonly met with.

It is easily understood how the reading of these chapters might excite the reproach, which was many times made against Professor Fournier, of "seeing syphilis everywhere" and of giving it an "exaggerated importance in pathology."

This criticism, which did not fail to reach his ears, had not the power to move him much. His reply to it is well known. It was first by demonstrating, with his exact and carefully differentiated descriptions, that he knew syphilis better than any one else; then by demonstrating in successive publications, the specific origin of several diseases or morbid states, frequent and severe, whose etiology was entirely obscure before he took them up. So this systematic tendency to look for syphilis everywhere, and to attribute an infinite number of ills to it, which was reproached as a defect in him, was on the contrary a fertile directing idea, in that it led him to real discoveries and contributed to the progress of medical science.

I may be permitted, before treating the subjects in which Fournier was clearly an innovator, to mention briefly the questions of syphilography to which his lectures or writings brought only an amplification of our knowledge. Here I shall not regard the chronological order of his publications.

They are: "Malignant Secondary Syphilids," of which he admits three forms, confluent, exfoliating and pigmentary; the roséoles de retour which recur so easily, and which are especially seen in patients who have been abundantly treated; "tertiary glossitis" in its two forms, sclerotic and gummatous; "gummata of the soft palate" and of the pharynx; "tertiary phagedenism"; "nasocranial osteitis" with its results often so grave; tertiary lesions of the anus and rectum, with the new description of the "ano-rectal syphiloma" and the study of the pathogenesis of stricture of the rectum; "syphilitic sarcocele," in which he points out secondary epididymitis, the sclerotic and gummatous forms; "syphilitic phthisis," failure to recognize which is so prejudicial to the patient; and finally he was one of the first to point out the part played by syphilis in the production of aneurysm, as well as its possible effect on the heart.

BOOKS ON THE ORIGIN, EVOLUTION AND TREATMENT OF SYPHILIS

But it is the large problems, the vital problems which attract him. When Fournier has reached the full maturity of his strength and talent, with twenty years experience and a well established reputation, he attacks the worst results of syphilis: the accidents of the nervous system which kill, which make invalids and dements; syphilitic heredity which is responsible for countless abortions, for hecatombs of new-born children, and for the birth of so many pitiful monstrosities.

The appearance of his book on "Syphilis of the Brain" (1879) really caused a sensation. While there was a vague idea of the existence of cerebral syphilis, there was far from being a clear idea of its diverse forms and of its real frequency. The author clearly points out the truly specific lesions and the lesions that result indirectly; under the name of initial forms he describes six of the more common clinical types; among them is mentioned the mental form, pseudogeneral paralysis, which will be the starting point for researches (1893 to 1895) on the syphilitic origin of general paralysis.

Then come in rapid succession two books of extraordinary importance; one on "Locomotor Ataxia of Syphilitic Origin" (1882), the other on the "Pre-Ataxic Stage of Tabes of Syphilitic Origin" (1885), followed by several articles and communications on hereditary syphilitic tabes and on various clinical manifestations of syphilitic tabes in general.

The relative frequency of syphilitic antecedents in tabetics had indeed been noticed; but it must be recognized that previous to Fournier's lectures delivered in 1875 and 1876 and collected by F. Dreyfous, and especially previous to the powerful argument of his book of 1882, no one had established a relation of cause and effect between syphilis and Duchenne's disease. Furthermore, this theory encountered a very active opposition, which was very slow in giving up the contest; I think that I am not mistaken in stating that even up to the time of his death, Professor Charcot actively opposed this theory. Nevertheless, harmony gradually came and Fournier's view is no longer contested. This discovery alone would have been sufficient to immortalize his name.

His researches on syphilitic tabes were to lead him to search also for a syphilitic origin of general paralysis, because of the manifest relationship existing between the two diseases. For ten years he pursues his search, accumulates proof and publishes nothing until he is convinced. Finally he commits himself in two articles in the *Bulletin Médical* (1883), and in a brilliant communication to the Académie de Médecine (1894), of which the proofs, arrangement and real eloquence were of such a nature as to make a strong impression on the thinking medical public. His opponents, to be sure, made an energetic and prolonged opposition, but what could they present against a mass of arguments furnished by the frequency of syphilis in general paralytics, by the correlation and frequency of syphilis and of general paralysis in different social surroundings, by the common association of general paralysis and tabes, and above all by the decisive argument of Regis' juvenile general paralysis?

Yet it is noticeable that, as was the case with tabes, Fournier did not go so far as to claim that all cases of general paralysis were syphilitic; he was satisfied that the connection, the relation of cause and effect should be acknowledged and that it should be conceded that "syphilis certainly was one of the most common and even the predominating cause of general paralysis." I cannot refrain, at this point, from saying that one of the last joys of his life was to learn of the discovery, made by Noguchi, of the spirochete in the lesions of general paralysis.

But twenty years ago a very impressive objection was raised against the new theory, namely, the objection that was then called the *faillite* (bankruptcy, failure) of antisyphilitic treatment in tabes and general paralysis. This fact, which he had noticed, led him to accept the theory of "Parasyphilitic Affections" (1894) which merits our attention for a moment.

Syphilis in addition to the extensive and complex group of "specific accidents" causes more and different things; it is also responsible for a large number of morbid manifestations which are syphilitic or heredito-syphilitic in origin, without however being of syphilitic nature. These parasyphilitic affections have a dual character: They may be produced without any syphilitic taint and, on the other hand, they are not influenced by mercury and the iodids as the true specific accidents are.

With this definition as a starting point, the author was logically led to associate and to group under the same rubric, such affections as the pigmentary syphilid, neurasthenia, hysteria, tabes, general paralysis, epilepsy, some progressive amyotrophies, hereditary dystrophies, hydrocephalus, Little's disease, etc. And this list does not exhaust the subject; he says that reasons will probably be found later for placing in the same category: diabetes, hemoglobinuria, some tertiary erythemas and perhaps lymphadenoma and one variety of alopecia areata. As to leukoplakia with the frequently resulting cancer, Fournier formally claims them for the same group at the International Congress of Dermatology in 1900.

That is certainly an astounding classification and one which presented many vulnerable points to the critics: they were not wanting, and I believe that many, even of those who fully accepted the theory of parasyphilitic affections, did so with some uneasiness. Yet, when we reflect on the genesis of this theory and on the import it might have in the mind of its author, we may imagine that for him the point in question was not the discovery of a law of general pathology, nor a revolution in nosology, but simply a conquest in the field of etiology. He did not pay much attention to explaining whatever mystery there may be in the opposition between the "origin" and the "nature" of a disease; he had an entirely different point of view: he was satisfied with having charged syphilis with several additional atrocities. His increasing hate of this plague is justified by this theory and he is more and more convinced that the necessary defense against it is an energetic repressive treatment and prophylactic measures which are of public interest.

The gravity of the prognosis in syphilis is chiefly due to its manifestations in the nervous system. The deduction from his "Researches on Tertiary Syphilis" (1889) is, that of all the organic systems, this is the one which most frequently suffers; if the specific virus is poisonous to the whole body, it is above all a "poison to the nervous system." But, still worse, we shall see that by its hereditary character syphilis is raised to the rank of a "poison of the race" and a "factor in depopulation."

Fournier's work on "Syphilitic Heredity" probably constitutes his greatest claim to fame; Besnier considered it the most remarkable part of his work.

In his communication to the *Académie* on the influence of syphilis on infant mortality (1885) he showed how deadly it is and proposed a number of defensive measures, which were approved by a vote of that body.

But it is his excellent book on "Late Hereditary Syphilis" (1886) which brings forth the greatest number of new and important ideas. To be sure, the early hereditary manifestations, with which children born of infected parents are threatened were not unknown; but fundamental ideas in regard to late manifestations were very vague and incomplete. The author in this book shows how astonishingly frequent they are, and how numerous and varied according to the organic system which is attacked. It had to be recognized that in innumerable accidents, which had been referred to scrofula, or in explanation of which an overloked infection of infancy was invoked, were really hereditary in origin. He points out with perfect clearness the elements of the positive diagnosis of hereditary syphilis, describing with precision stigmata of different kinds, cranial and nasal deformities, saber-shaped tibia, and especially dental changes, which are very minutely studied. At the time of the publication of this work the author states that he has, thus far, not met with a single indisputable evidence of herediary syphilis originating in a patient over 28 years of age, though he very correctly foresees that some will be disclosed in the near future.

In relation to the concrete study of hereditary syphilitic accidents, the question of "Syphilitic Heredity," of its forms and of its laws, has a considerable scientific and practical interest, on account of the complexity of the problems involved. In a series of lectures on the subject, edited by his pupil, Dr. Portalier (1891), these problems are analyzed, dissected and examined from all sides.

Naturally the question of paternal heredity, of conceptional syphilis, of syphilis by *choc en retour* and Colles-Baumès' law, especially attracted his attention. But besides he insistently recurs to the high infantile mortality; in addition to the transmission of syphilis *en nature,* of fetal cachexia which results in "unfitness for life," he points out the hereditary dystrophies and malformations which form another category of deadly results. The exposition of these imperfections or retardations of development, dystrophies or monstrosities were more fully treated in a memorable discourse at the Académie (1889). The possibility of heredity of the second generation is discussed and formally declared acceptable in the "Treatise of Syphilitic Heredity"; but Professor Fournier does not yet consider it definitely established.

We may imagine his feelings of paternal joy and pride when he saw several of the problems which had attracted him, solved in the way he had foreseen by the work of his son, Dr. Edmond Fournier! It will suffice to mention the exhaustive study of the dystrophic stigmata, the proof of hereditary syphilis in the adult and in the aged, and the demonstration of hereditary syphilis of the second generation.

The reception accorded his works on syphilitic heredity, not only in our own country but beyond our frontiers, was a great satisfaction to Professor Fournier. His book was everywhere received with admiration and gratification; a translation was published in Vienna, somewhat enlarged by notes and discussions, which in no way enhanced its value. He took up the subject again several times, and quite recently in his pamphlet "Four Mistakes That Should Not Be

Made," he emphasizes the medical consequences of the principles which he had established and pleads "for the unfortunates who are threatened with a heritage of syphilis." With him veneration for science is never separated from the love of humanity.

Having completed the consideration of Fournier's most important achievements, his work on the origin, evolution and treatment of syphilis remains to be reviewed.

The origin of syphilis, and especially of nonvenereal syphilis, always keenly interested him. There are, indeed, aside from heredity, numerous ways of contamination which menace husbands and wives, nurses, physicians, midwives, etc., in a word, a long list of innocent victims. This "unmerited syphilis" is much more frequent than is suspected by those persons who believe that venereal disease is a monopoly of the fast set (monde galant) and the fruit of debauch. Such cases run great risk of being wrongly diagnosed and of increasing the number of cases of "unrecognized syphilis" (syphilis ignorées); for various reasons they are not properly treated, and hence their prognosis is appreciably more unfavorable.

Several times Fournier came back to the subject of conceptional syphilis. In his book on "Syphilis and Marriage," the success of which is shown by two successive editions (1888-1890) and by six translations, this question is treated along with all those which are related to the many dangers of family syphilis. "Syphilis in Married Women" (1887) and "Syphilis in Innocent Women" (1906) were used as arguments in favor of prophylaxis before the Académie.

He was also always disturbed by the fate of wet nurses, infected by the children entrusted to them and by the various consequences originating in contamination of this sort; he codified, so to speak, the duties incumbent in such cases on the physician, on the nurse and on the medicolegal expert. He also considered the inverse situation, that of a nurse in the contagious stage infecting her suckling, and he reports the history of a family epidemic in which there were seven victims.

We must also recall his book on "Vaccinal Syphilis" (1889) which certainly helped to bring about the substitution of animal for human vaccine—universally accepted today; his article on "Medical Contagion" (1891) which is transmitted by the physician, with the aid of his hands or his instruments, or which is contracted by him and is often manifested by a chancre located at the eye or on the fingers; and his large experience as a medicolegal expert which brought under his observation about all the different ways in which syphilis may be transmitted.

Some questions related to nonvenereal syphilis, professional or accidental, are incidentally considered in his "Lectures on Extragenital Chancres" (1897) which were collected by Edmond Fournier. In this well illustrated volume is found the personal description which the author gave of chancres of the fingers, of the eye and of the tonsil, which is today classical. The question of prognosis of extravenereal syphilis, reputed to be graver, is also clearly asked and answered; he concludes that syphilis of this variety is no graver except for individual circumstances of the contaminated subject and on account of the habitually insufficient treatment.

His publications relative to the "Evolution of Syphilis" are numerous and treated with evident predilection.

With great clinical sense, he analyzed the factors in the gravity of syphilis (1886) and described secondary malignant syphilids (1893).

But tertiary syphilis, the conditions which favor its outbreak, its manifestations and its consequences, offered a greatly superior interest and was the object of several of his most important researches. His "Researches on Tertiary Syphilis" (1889) and his "Early Tertiary Syphilis" (1894) demonstrated from personal statistics the unsuspected fact that tertiary accidents are met with as soon as the end of the first year in hardly less than 8 or 10 per cent. of the cases; that they are constituted chiefly by cutaneous lesions and

nervous manifestations; that myelopathies are relatively frequent and grave since they caused death in sixteen of fifty-two cases. In the same year the author introduces us to the very late manifestations of tertiary syphilis, those which put in their appearance thirty to fifty years after the chancre.

The sequel of "Early Tertiary Syphilis" is "Late Secondary Syphilis" (1906), of which Fournier gives the picture that he drew from the analysis of his collection of 19,000 case histories! Contrary to the classic opinion, cutaneous syphilids of the secondary type a little modified in their appearance may often be observed in the fifth or sixth years, and after that with decreasing frequency. That is strange, but something more important follows: in the same way genital, and especially buccal mucous patches may appear even as late as the tenth year and perhaps later, though no later ones were authenticated. This explains late contagion of which definite observations are known. It is treated, but insufficiently treated syphilitics and especially smokers who present these anachronistic manifestations; the therapeutic and prophylactic indications to be deduced are evident.

The book on the "Treatment of Syphilis" (1893-1909), as is easily believed, had a considerable success: three editions did not diminish it. When the first appeared, mercurial injections had already come into vogue; the third preceded by a short time the introduction of the new arsenical compounds. Every general and individual question of treatment is studied. The principal interest is in disputed questions—the practice of the exicsion of the chancre, the relative value of the various mercurial injections, etc. The general tendency of the author is conservative; he refrains from enthusiasm and hesitates to abandon established practices for inadequately proven innovations. He cannot make up his mind to advise the use of gray oil as the routine method of treatment; I know how much he was impressed by the frequently extraordinary efficacy of calomel in certain cases, yet he retains his preference for pills and inunctions and especially for the mixed treatment with mercury and the iodids.

Especially are to be praised the recommendations from his vast experience in regard to the general direction of treatment. At the beginning of his career it was the general practice to treat accidents until their disappearance; syphilids were treated, but not the disease. He, who had been able to convince himself that mercury in addition to its curative effects is endowed with a preventive action, had, on this fact based his "chronic intermittent treatment," which was accepted and to which he remained faithful. We should not neglect to emphasize the support which was given to his theory by the method of control by the Wassermann reaction.

At the end of his career, instructed by his researches on the consequences of tertiary syphilis and of the parasyphilitic affections, he advised prolonging the treatment beyond the time previously fixed; he advised interspersing biennial courses of treatment between the fifth and tenth years in order to intensify the preventive action of mercury at the most dangerous periods. "Sterilize" syphilis at its onset and prevent it from provoking dangerous accidents and from being transmitted to descendants is the goal which one should attempt to reach. He showed that with clinical tact and with perseverance the equivalent of a cure may be obtained.

Professor Fournier had dreamed of uniting all the substance of his teaching in his great "Treatise of Syphilis," of which the first part appeared with the collaboration of his son, in 1898. Three other parts have appeared since then, including the primary and secondary stages, and a study of only a part of the accidents of the tertiary stage. It appears to me entirely superfluous to insist on the value of this magnificent work, as it is in the hands of everybody.

Do you wish to know what the recreations of this indefatigable and persevering worker were? To translate, himself, to annotate and to publish edi-

tions de luxe of the works of the first observers of the French disease, Jean de Vigo, Jacques de Bethencourt and Fracastor; to write a "Letter of Jean de Vigo from Beyond the Grave," or a "Lecture on Syphilis in 1830"; he allowed himself no others.

HIS CAMPAIGN OF SOCIAL DEFENSE

At last, I come to that part of Fournier's work which is, so to speak, its crown, its conclusion, its fulfilment, namely, his campaign of social defense by the prophylaxis of venereal diseases.

We have seen, in the preceding pages, the tenacity with which he persisted in this lofty aim from the beginning to the end of his career. The frequency of syphilis, its terrifying power of diffusion, its indirect ricochets on so many innocent persons, its terrible consequences to the individual and to the race, all impose an urgent duty on him who has demonstrated them. The resources which medical treatment furnishes against such a plague are without doubt of great value, but yet wholly inadequate. To attempt to struggle alone in one's hospital service and office, however enlightened, however active, however devoted to the task one may be, is to be resigned to being only a stone in a torrent, in a place where a dam is needed.

He understood that what was needed was the beginning of a crusade; he raised the flag himself with the enthusiasm of conviction, and kept it high and steady till his last breath.

Seizing every opportunity that was offered, creating them himself if necessary, he made the hall of the Académie de Médecine and those of the International Congresses resound with his eloquent and urgent appeals; with his articles, his reports and his books he urged the public authorities to rouse themselves from their apathy and urgently prayed them to come to the aid of the medical profession in safeguarding the public health.

He did still more. In March, 1901, he founded under the name of the "French Society of Sanitary and Moral Prophylaxis," a veritable "League Against Syphilis." In addition to hygienists, he gathered into it lawyers, philosophers, men of letters, all the men who were inspired with ideas of progress, of justice and of charity.

In this way he wished to create an agitation, a public opinion and to increase his own moral influence, with the object of popularizing the idea of the venereal peril and of obtaining the enforcement of practical measures which seemed to him indispensible. That it was he who furnished the facts for the authors who attempted to enlighten the public on the dangers of "damaged goods," (l'avarie), is an open secret. Those who most need the teaching are the young people who expose themselves to contamination, frequently with so little knowledge of their danger; so it was for them that, at the request of the "Society of Prophylaxis," he edited the pamphlet entitled "For Our Sons When They Reach Twenty," which is a small masterpiece of tact and real humanity. To him also we chiefly owe the lectures and the administrative and medical regulations designed for the protection of the army and navy.

He collected his chief publications on the subject into a large volume, the "Prophylaxis of Syphilis" (1903). In it he reviews the various means which may be of use in attaining the end in view. The means of a moral and religious nature, which are so respectable, but unfortunately of so little practical value, inspired some well written pages. He expects better results from the surveillance of prostitution by administrative and police measures, but he energetically recommends that they shall be placed on a firm legal, not an arbitrary basis.

We remember that the controversies incited by his plan of regulation caused him to break a lance with the "abolitionists." He maintained that the great gravity of venereal diseases, and especially the menace with which they threaten the wife and the child, gives society the right of defending itself

against them. To the argument based on the liberty and self-respect of the prostitute, he replies that the public interest often imposes a limitation on the liberty of everyone, for example military service and the management of unsanitary trades and industries.

The medical methods he recommends are the hospitalization of patients, surveillance of wet nurses, animal vaccination; he recommends not only the treatment of syphilitics but their instruction in the dangers to which they expose their associates. He criticizes the organization of the venereal clinics of our hospitals, and suggests the establishment of numerous, less public dispensaries. He insists especially on the need of giving physicians longer and more complete instruction in syphilis, recognizing that, in the last analysis, it is they who must play the chief rôle in the preservation of society.

In conclusion, I will briefly describe the professor, the writer, the teacher and the practitioner.

Few men have possessed the taste and talent for teaching to the same degree as did the teacher of Lourcine and of the Hôpital Saint Louis. To impress on his pupils the truths to which his experience had led him, was not enough for him; he constantly devoted himself to deducing from them the necessary conclusions and the rules for practical guidance. So he strove not only to instruct but to persuade. It might be said that the majority of his lectures and almost all of his academic addresses are veritable pleas.

His ease of speech, the eloquence and correctness of his style, were quite remarkable. In order to be sure of communicating his thoughts with all their shading, and of causing them to penetrate better into the minds of his auditors, he liked to use synonyms, gradation and superposition of analogous terms. The arrangement of his discourses, their architecture, if we may use the expression, appeared to him not unworthy of his care. He had so great a gift of visual memory and of mental reproduction that he could literally repeat the text of his lectures, which he delivered almost in the manner of extemporaneous talks, as he turned the pages before him, rarely glancing at them.

The success of his teaching was considerable; into his always filled amphitheater crowded a great number of his former pupils, as well as physicians from every land who, attracted by his universal renown, were sure not to be disappointed either in the subject matter or the form.

His lectures were so well prepared that they could be printed without revision. In fact, the greater part of his publications is only the exact reproduction of lectures or academic discourses; as we read them we seem to hear him still.

The material for his work was in large part derived from his hospital practice; he always found time on his service to study thoroughly and from all angles the cases which were within the bounds of the researches he was at the time engaged in, or which were of such a nature as to open new horizons.

But a no less important part of his material came from his private practice. From the very beginning of his career, following the example of his teacher, Dr. Puche, he had formed the habit of keeping a written note of each visit of each of his patients; this habit made it possible for him to amass in fifty years a veritable pathologic treasure. He says somewhere, "I made myself a collector of syphilitic data, just as a fad or special interest invites others to become collectors of paintings, of books, of Japanese articles, of autographs, of snuff-boxes, etc. . . . Thanks to these notes, I was able first, to convince myself and later to convince my colleagues of the pathogenetic relationship which attaches tabes, and general paralysis, and leukoplakia, and the specific hereditary dystrophies, to syphilis."

With renown, a large practice came to him; for half a century innumerable patients from all over the world filed into his consulting room, attracted by his exceptional knowledge, but also attracted by his good sense, by his perfect honor, and by the radiance of benevolence which emanated from him.

Who can tell how many poignant distresses, how many private tragedies were confided to him! How many misfortunes were averted or alleviated by his fatherly advice or by some comforting words!

As if the result of an obsession, the unfortunate cases of which he was a witness, always brought him back to that hatred of the plague, which syphilis is, and to the methods for conjuring away its evil results, in short, to prophylaxis. And the stereotyped exclamations which recurred on the lips of his patients, thoughtless evil doers as well as innocent victims—"I didn't know," and "Why, then I am done for"! led him to popularize his teachings for the sake of humanity. The little pamphlets which are dated during the last years of his life, entitled *"Doit-on le dire?" "En guerit-on?" "Pour en guerir," "Pour nos Fils," "Trois Fautes à ne pas Commettre,"* were certainly the result of this feeling of compassion for humanity, which in any case is suffering, and which is often ignorant and sometimes guilty.

If, in the evening of his career, Fournier looked back over his life, which had been wholly consecrated to work and to duty, over the trail which he had blazed, over his masterly and enduring work, he certainly was able to feel a legitimate pride; but I believe that the title, which above all others he would have liked to see given him, is that of benefactor of mankind.

ERNEST GAUCHER
1854-1918

Prof. Ernest Gaucher died in Paris, Jan. 25, 1918, of an obliterating thrombotic aortitis, following an attack of pneumonia, the crisis of which had been passed.

He was an intern of the Paris Hospitals in 1877, took his medical degree in 1882, Chief of a Medical Clinic from 1882 to 1884. Among his teachers were Potain, Bouchard, Landouzy, Hillairet, Bucquoy and Fournier.

He became physician of the Paris Hospitals in 1886, physician of the Hôpital Saint-Antoine in 1892, and Professor *agrégé* in the same year. In 1902, he was appointed Professor of Cutaneous Diseases and Syphilography, of the Faculty of Medicine of the University of Paris, succeeding Alfred Fournier.

At the outbreak of the war, although his age freed him from all military obligations, he desired to be a military physician, and was made Chief Physician of the Villemin Hospital. He took full charge of its organization and was at its head until his death.

He received many medical honors: He had been Vice-President of the French Society of Dermatology and Syphilography; President of the Medical Society of the Hospitals of Paris; President of the General Association of French Physicians; he was elected a Member of the Academy of Medicine in 1910; and on July 14, 1917, he was made an Officer of the Legion of Honor *au titre militaire*, in recognition of his services as Chief Physician of the Villemin Hospital.

Professor Gaucher was a constant writer. Among the books he published are: "A Theoretical and Practical Treatise on the Diseases of the Skin (in collaboration with Hillairet); "A Treatise of Dermatology" in Brouardel and Gilbert's "Treatise of Medicine"; and a "Manual of Syphilography" in collaboration with several authors.

In 1906, he founded the "Annales des maladies vénériennes," and was always one of its chief contributors.

It is unnecessary to mention the titles of his numerous articles on dermatology and syphilis. It should, however, be noted that he became medically known by his doctoral thesis on "Primary Epithelioma of the Spleen," a disease which soon became known as "Gaucher's Disease."

When Gaucher succeeded Fournier, it was quite natural that he should have devoted most of his attention to syphilis, and his writings since that time

have dealt chiefly with that disease. While it is perhaps unfortunate for Gaucher it is still inevitable that the two syphilographers should be compared.

Fournier was one of the great leaders of the medical world of the nineteenth century, and the importance of his work is becoming more and more apparent as it becomes better known and as it is confirmed by the scientific demonstrations of recent years.

Gaucher, on the other hand, did little lasting constructive work, and even among his friends during his life time, was considerably discredited as a syphilographer because of his innumerable erratic, unwarranted and even rash statements about that disease

It is unnecessary to mention more than a few of his best known aberrations. Several years ago he gave appendicitis a syphilitic origin, and was always convinced that he was right in so doing. Infantile paralysis he had also classed as syphilitic. He saw hereditary syphilis in nearly all deformities, even to nevi, and was convinced that separation of the upper median incisors was a stigma of the disease. It seemed as if he could not admit that any other disease might cause dental malformations.

Gaucher was always pugnacious, and was never disturbed at fighting without allies. He was an enthusiastic opponent of the injection of the insoluble salts of mercury in the treatment of syphilis, and delighted to rehearse all the accidents that they caused.

But the opposition he made to them was as nothing compared with the rabid and frenzied fight which he, almost alone, waged against salvarsan—which he called "that *boche* commercial product"—from the day of its first use till the day of his death. In the same number of the "Annales des maladies vénériennes" that announced his death, one of his own articles on the subject appeared, in which he said, "we must remain faithful to the traditional therapeutics of syphilis, remain faithful to mercury, which is, today as formerly, the chief—I was about to say the only—remedy for syphilis."

Two months before his death he published an article entitled "606, or the German Poison."

Of course, no one took his writings or his lectures on this subject seriously.

One of the most striking and original personalities of the French medical world has disappeared. Gaucher was a man of many contrasts, a combination of characteristics rarely united in the same individual. He was essentially a fighter (or perhaps "scrapper" would better express it) of an overbearing disposition, rough in his dealings with friends and foes, and yet with a kindly heart. One of his closest associates described him as *ce bourru bienfaisant.*

An intimate friend who was with him at the end, says of him: "A rough exterior, a man difficult to get along with, an excellent heart, charitable feelings; these are his essential characteristics. His high moral worth, his integrity and his professonal uprightness, the rectitude of his sincere soul, earned the respect of all of his confrères, even of those who were separated from him, scared away by his tirades and his uncompromising scientific opinions."

Another says: "A charitable heart under a mask of crabbed harshness; open and devoted friendship, with a disagreeable disposition; upright, and with strong faith in scientific and moral truth, under a disturbing veil of paradox and of scepticism; he was greatly loved because he was good and charitable."

Professor Gaucher visited the United States several years ago, and carried back with him the most pleasant recollection of his visit and of the friends he made among the physicians here—a visit of which he delighted to talk.

It was undoubtedly a result of the interest in America aroused by this visit that the writer, though at the time unknown to him, was cordially received, and, during a year's sojourn in Paris, treated as a friend by Professor Gaucher. During that time he learned to value the man and the friend, under the mannerisms which were at first rather disturbing. - J. E. L.

Correspondence

AMERICAN NAMES FOR LICENSED SYNTHETICS

To the Editor:—Professor Stieglitz, Chairman of the Subcommittee on Synthetic Drugs of the National Research Council, has asked me to send you a letter for publication.

On behalf of the committee, he urges that you advise the use of the Federal Trade Commission's recommendation to employ the official name of the licensed drugs in connection with all written articles and advertisements, and if the proprietary brand name is to be used, to place this side by side with the official name.

The official names so far adopted by the Federal Trade Commission are:

Arsphenamine for the drug marketed as: salvarsan, diarsenol and arsenobenzol, etc.

Neoarsphenamine for the drug marketed as: neosalvarsan, neodiarsenol and novarsenobenzol, etc.

Barbital for the drug marketed as veronal.

Barbital-sodium for the drug marketed as medinal and veronal-sodium.

Procaine for the drug marketed as novocaine.

Procaine nitrate for the drug marketed as novocaine nitrate.

Phenylcinchoninic acid for the drug marketed as atophan.

The following is the letter submitted by Dr. Stieglitz:

W. A. Puckner,
Secretary, Council on Pharmacy and Chemistry, American Medical Association.

It appears that in certain quarters the attitude is taken that the local anesthetic sold as procaine is not identical with that marketed as novocaine. The Subcommittee on Synthetic Drugs of the National Research Council believes it important that this misunderstanding should be corrected and hence offers the following explanation:

The monohydrochloride of para-amino-benzoyldiethyl-amino-ethanol, which was formerly made in Germany by the Farbwerke, vorm. Meister Lucius and Bruening, Hoechst A.M., and sold under the trade marked name novocaine, is now manufactured in the United States. Under the provisions of the Trading with the Enemy Act, the Federal Trade Commission has taken over the patent that gave monopoly for the manufacture and sale of the local anesthetic to the German corporation, and has issued licenses to American concerns for the manufacture of the product. This license makes it a condition that the product first introduced under the proprietary name "novocaine" shall be called procaine, and that it shall in every way be the same as the article formerly obtained from Germany. To insure this identity with the German novocaine, the Federal Trade Commission has submitted the product of each firm licensed to the A. M. A. Chemical Laboratory to establish its chemical identity and purity, and to the Cornell pharmacologist, Dr. R. A. Hatcher, to determine that it was not unduly toxic.

So far, the following firms have been licensed to manufacture and sell procaine:

The Abbott Laboratories, Ravenswood, Chicago.

Farbwerke-Hoechst Company, New York.

Rector Chemical Co., Inc., New York.

Calco Chemical Company, Bound Brook N. J.

Of these, the first three firms are offering their products for sale at this time, and have secured their admission to New and Nonofficial Remedies as brands of procaine which comply with the New and Nonofficial Remedies standards.

While all firms are required to sell their product under the official name "procaine," the Farbwerke-Hoechst Company is permitted to use the trade designation "novocaine" in addition, since it holds the right to this designation by virtue of trade mark registration.

In conclusion: Procaine is identical with the substance first introduced as novocaine. In the interest of rational nomenclature, the first term should be used in prescriptions and scientific contributions. If it is deemed necessary to designate the product of a particular firm, this may be done by writing procaine-Abbott, procaine-Rector, or procaine-Farbwerke [or procaine (novocaine brand)].

JULIUS STIEGLITZ, Chairman,
Subcommittee on Synthetic Drugs, National Research Council.

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